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ABSTRACT

This report is directed particularly to state mental health agency directors and members of their management teams and support systems such as the budget offices, legislative committees and board members. Through a survey of the status of mental health program evaluation within the state mental health agencies in the South, it was found that few state mental health facilities have access to guidelines for setting and maintaining standards. This report is offered to those professionals needing guidance and recommendations on whether or how to set standards. The report covers three broad areas: (1) major issues in the development of standards, (2) management uses of standards and (3) conceptual issues in standards. (Author/PC)

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APPLYING STATE MENTAL HEALTH STANDARDS:
MANAGEMENT USES

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APPLYING STATE MENTAL HEALTH STANDARDS

MANAGEMENT USES

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FOREWORD

The Mental Health Program of the Southern Regional Education Board (SREB) was established by the Southern Governor's Conference in 1954 to facilitate mental health training and research. One of the areas of research that has come to the fore in the past five years is program evaluation. SREB undertook a project to facilitate state level mental health program evaluation under contract number ADM-42-74-90(OP) from the National Institute of Mental Health (NIMH) in 1974. It has become apparent that one of the major concerns of the states in the overall area of program evaluation is that of setting, monitoring and using mental health standards. Most state mental health agencies have little experience in the development and use of standards of their own, although they have long been concerned with helping their operating programs to meet the standards of outside organizations such as the Joint Commission on the Accreditation of Hospitals.

For the past year the SREB project has focused its efforts on the matter of state level mental health standards. This publication sets forth the issues and recommendations of the program evaluators and standards administrators who worked with SREB staff as a "Committee of the Whole" and as subcommittees to pool their experience and judgments.

We are grateful for the support of the NIMH and for the assistance of Mr. Cecil Wurster who was project officer and to Dr. Ben Liptzin who attended several meetings. We also appreciate the work and the time of the Committee of the Whole which was made up of program evaluators and standards administrators from the 14 states of the South.

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INTRODUCTION

In the summer of 1974, when the Mental Health Program of the Southern Regional Education Board undertook a project* to facilitate state level mental health program evaluation, the 14 states of the South were surveyed to learn more about the status of mental health program evaluation within the state mental health agencies. The project also surveyed which aspects of program evaluation were of special concern and found that one of these was the matter of state level standards.

Until recently most state mental health agencies gave little systematic attention to standards other than to help their operating programs to meet the standards of various outside agencies such as the federal government, the Joint Commission on Accreditation of Hospitals or the state health departments. Under a variety of stimuli from third party payers, court orders, legislative mandates, advocacy groups and the overall complexity of the systems for which they were responsible, several states have either developed and are beginning to use standards for various aspects of their programs, or they are seriously contemplating doing so. However, there are few guidelines for such an endeavor.

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*The *Program Evaluation Project,* supported by Contract No. ADM-42-74-90(OP) from the National Institute of Mental Health.

In March of 1975 the Program Evaluation Project sponsored a regionwide workshop on the subject of "Setting and Monitoring Standards in a State Mental Health Agency." (A report of the workshop is available from SREB.) One of the recommendations of that workshop was a request that SREB give further assistance to the states in formulating guidelines for developing, monitoring and using standards within a state mental health agency.

Since the summer of 1975, the project, with further contract support from NIMH, has turned its attention to the matter of standards. An overall Committee of the Whole was chosen, made up of the persons with major responsibility for standards activities within the 14 state mental health agencies. In some cases, these were the same persons who had primary responsibility for program evaluation, but they were often different persons. The Committee of the Whole (which is listed in Appendix A) met several times during the year. There were also smaller subcommittees that met with staff to discuss specific aspects of standards, to pool their knowledge, experience and judgments and to prepare a publication of issues and recommendations regarding the use of standards by a state mental health agency.

The project staff conducted a survey of the activities of the state mental health agencies in the area of standards. A report of that survey is given in Appendix B.

The project also conducted a regional workshop in December of 1975 on the more practical and operational aspects of standards setting and monitoring. The report of that workshop was published in *State Mental Health Standards: How To Do It*, which is available from SREB.

This publication is the result of all these activities. It offers guidance and recommendations to persons in state mental health agencies who would be most concerned with whether to develop and use state mental health standards and, if so, how to proceed. If standards are to be used, then their primary use should be as management tools to assure a higher quality of mental health care within reasonable resources rather than as coercive devices to simply control costs. This publication is thus directed particularly to state mental health agency directors and members of their management teams and support systems such as the budget offices, legislative committees and board members. It also is designed for persons within the state mental health agencies who are responsible for developing, monitoring and generally administering standards programs. And it may be of interest to representatives from citizen advocacy groups, professional societies and third party payers.

Chapter 1 of this report provides a summary overview on developing, monitoring and using standards along with some of the issues still to be addressed and some potential problem areas. The later chapters go into various aspects of standards setting, monitoring, staffing, etc. in more detail. It was decided to use this format—a rather terse overview chapter to begin the report—so that the reader would quickly have a whole picture; the later chapters will then have more meaning in the context of an overall standards program.

CHAPTER 1

MAJOR ISSUES IN THE DEVELOPMENT OF MENTAL HEALTH STANDARDS

This first chapter is an overview of standards as they might be developed, monitored and used by a state mental health agency and provides a comprehensive look at the issues to be considered in the matter of standards. The later chapters will expand on individual aspects, and will offer much more detail and exploration of the issues and alternatives.

The state level mental health administrator and his staff must first of all decide whether to have standards. A decision must then be made on what objectives are to be met, and whether standards are the best way to meet them. The dispersal of the mental health delivery system to a number of community based programs where they are more difficult to direct and review makes the use of standards more desirable now than formerly. Furthermore, the demands for accountability from third party payers, legislatures, federal agencies and advocacy groups are making standards increasingly necessary. But the state mental health administrator still has the option of not setting a standards process; instead he may simply help the operating programs to meet the many outside federal, national and state health department standards.

MANAGEMENT USES OF STANDARDS

A major purpose of having a state level standards program is to improve the overall management of the mental health programs for which the state agency has responsibility. Standards can be used only to assure that programs are in compliance with some outside group's expectations, but a much more significant use is to improve the internal management of the mental health agency itself.

While standards have the overall purpose of assuring clients, families and support groups of the quality of facilities and services, the state agency has the option of several specific uses of standards. Among them are:

Licensure

Accreditation

Detection and correction of deficiencies

Decisions about allocating funds

Program development

Staff development

Program evaluation

Cost control

Legal protection

Assuring fund entitlements

Assuring that programs remain within previously agreed-upon parameters.

Some of these uses are inherently more authoritarian than others. Mental health standards began as entirely voluntary measures of program quality, but recently there has been a trend to use standards in more regulatory and controlling ways. The state mental health administrator will want to think this issue through carefully. Rewards and facilitation are usually more effective motivators of behavior than punishment and control. The standards may be developed and monitored to meet both kinds of uses, but the administrator will want to be careful about the overall tone, procedures and applications to assure that the authoritarian aspects do not predominate and cast a controlling image over the whole process.

This will require careful attention in announcements, procedures, wording and application of sanctions and rewards based on standards. The administrator will also have to use great care in selecting and supervising the persons who administer the program.

Some of the uses of standards are highly regulatory and will be developed in a formal process for filing as state regulations. Others are administrative procedures or directives within the agency itself. And others are more in the nature of optional guidelines for programs. Thus, the tone of the standards will range from a mandatory base of required items to a set of optimal or ideal items that are expected to be useful to programs. In between are intermediate levels of standards that may be useful for differential levels of funding or programming.

Regardless of the uses to be made of standards, it is well to keep in mind that standards are only measures. They are not regulations, directives, orders, etc. However, the standards are often contained within these various administrative directives as measures that are considered to be evidence that the conditions of the regulations are met. Sometimes standards are stated in numerical terms that denote how many, how much, etc. This is particularly true of standards that are based on the norms from a large sampling of similar programs. Other standards are written so that the answers are "yes" or "no," particularly standards which the standards setters have judged to be desirable characteristics of programs without reference to any sampling of programs. These standards are likely to be qualitative items such as quality-of-life standards or standards relating to confidentiality.

Standards may be written for *inputs* of programs or facilities (i.e., space standards or staffing standards) or for *processes* (i.e., the operating procedures), or for *outcomes* of programs. (While industry commonly bases its standards on outputs which can be easily observed and measured, the human service programs have been more inclined to set input or process standards, because of the fact that there is little consensus about outcomes on which standards could be based). Standards may be written for facilities, programs, clinical services, administrative services or support services (i.e., pharmacy, dietary, volunteer services).

The mental health administrator will do well to exercise great care in the development, implementation and use of a standards program to assure that it is working to facilitate program development. He must also be alert to detect and correct early problems that may jeopardize the whole program if allowed to go on unresolved.

DEVELOPING STANDARDS

Once the decisions have been made about whether to have standards and which kinds to have, the agency will undertake the standard setting process. This involves three stages: planning, writing and promulgation.

PLANNING

A first step is to have a decision from management that standards will be formulated and used. Then the persons responsible for developing the standards will familiarize themselves with the many federal, national and state standards that already impact on the state's operations. In many instances it will be sufficient to use the existing standards of these other organizations.

The standards developers will also need to decide which are the significant aspects of programs that the standards are to address. There is no point in writing standards for inconsequential aspects of programs.

DEVELOPMENT

The persons responsible for standards development will also analyze the expectations of agency leaders, legislators, client groups, etc., about standards and their impact on programs. It is especially important to identify the *philosophies* upon which the programs and standards will be based. Failure to make the philosophies explicit is a major cause of later conflict about standards and how to interpret them.

The standards developers should also decide in the planning stages all of the uses that are to be made of the standards, because the uses will determine what the standards will be, how they will be worded and how they will be monitored.

A proposed plan of development is then prepared and submitted to the management team of the agency for approval and modification. The proposal may suggest a committee approach, a consultant approach, or a library approach, or some combination.

WRITING

The standards writing process is tedious, but it will be greatly speeded if the initial planning has been thoroughly done. Each standard contains a carefully stated series of items to be used to measure an element of a program or facility. It is followed by statements of definition, purpose and interpretation. The standards will specify the levels of performance or the characteristics of programs so that they can be accurately and reliably measured. They will ordinarily avoid jargon or technical terminology, and their language will vary depending on whether they are mandatory, intermediate or optional standards.

Standards ordinarily provide an element of flexibility by holding mandatory standards to a minimum and offering a range of acceptable measures for items whenever possible. This will allow for geographic, economic or technological variation.

The overall standards program should strive to cover only essential items. It should provide flexibility within items, but the program should remain relatively stable so that all persons affected by the standards can know what to expect.

The standards document will have an introductory statement of purpose, a glossary, a statement of the monitoring process, a statement of the uses to be made of the standards and the procedures for appeals.

After the document is prepared, it is given wide circulation for review and comment by persons who will be affected by the standards. After appropriate revision and approval by legal counsel, the standards are usually field tested and given a final revision.

PROMULGATION

The standards are then implemented by agency directive or, if they are to become part of formal regulations, they are filed with the appropriate state agency and published in the state's administrative register. The standards are promulgated to all who will be affected; orientation programs are conducted and mechanisms are set in place for consultation and other forms of technical assistance.

It is also important to design a process for evaluating the standards and the monitoring process, both as they are implemented (to identify and resolve any problems) and over a longer period of time to plan appropriate refinements and revisions.

MONITORING

Monitoring is the process of gathering data to measure how actual program performance compares with the standards and to develop plans for correcting any deficiencies. The results of monitoring may also be used for decisions about licensure, allocating funds, evaluating programs, identifying problem areas, comparing programs and preparing staff development programs. Monitoring is a key step in reporting to administrators, legislators, funders, and the public how well the programs are achieving their specified levels of care.

In preparation for monitoring there will be considerable education, both for persons in the programs to be monitored and of the persons who will do the monitoring so that all are familiar with the procedures and how they will be applied. Training for surveyors is especially important to assure that they are knowledgeable about the standards and psychologically prepared to be surveyors.

There are several questions to be decided about monitoring: whether there will be allowable variations for programs with different forms of organization, resources, etc.; whether there will be weighting of certain items; whether the measures are valid and reliable; and what degree of compliance will be expected (substantial, real or full).

The monitoring itself may be done by review of data from reporting forms or by review of clinical records, or by visits to overall programs, or by inspection of premises—or some combination of these. There are several methods of monitoring that may be used:

Self-reporting

An inspector general

An interdisciplinary survey team

Peer review

Audit review of selected items

All except self-reporting require a survey visit which involves scheduling, conducting an orientation session at the start of the survey visit, and a conference at the close at which the findings are reported. This is followed up with a written report stating strengths, weaknesses and areas requiring correction.

The program is then asked to submit a plan of correction for any areas found to be out of compliance.

There are several potential problems and conflicts in standards programs. Among them are:

Overlaps and conflicts between the standards of different agencies

Standards being used for purposes other than those for which they were intended

Frequent changes in standards

Credibility concerns when the same persons set and monitor standards

Conflicts between quality assurance and cost control

Costs of preparing for site visits.

ORGANIZING AND STAFFING

In organizing and staffing a standards program within the state agency, there are many options. Basically these focus around centralization versus decentralization. There may be a completely centralized program in a department of human resources; or in a department of mental health; a regionalized program; or a program decentralized to individual program areas (i.e., alcohol programs, mental retardation programs, mental hospitals).

Full-time staff may be employed for developing and monitoring of standards or the personnel may be drawn from other agency operations. There are advantages and disadvantages of each, but overall there are real advantages to having at least some full-time staff devoted to the standards program. There are also advantages to separating the persons who develop standards from those who monitor them. The developers are much more likely to be drawn from the operating programs while the monitors are more likely to be from a standards office.

The standards office may be an independent office attached to the staff of the agency head, or it may be combined with various other offices such as evaluation, program services, or administrative services. In any case, it will have functional relationships to all of these as well as to staff development and to the field operations.

The standards office should see itself as an integral part of management that makes its reports in timely, concise and readable form. The office must be aware of the administrator's philosophies and yet carry out its work in as objective and facilitative a fashion as possible, with proper attention to the overall social, political and professional context within which the agency functions.

There is no specific training program for a standards administrator. The job is primarily administrative rather than clinical; however, it is well for the person to be a skilled clinician and program director who has broad understanding and experience with the program areas to which the standards will apply. The persons who do the site surveys must be knowledgeable about the program areas and the kinds of facilities about which they are making judgments.

Standards administrators must have a sense of organization and a sense of systems to envision all of the purposes, philosophies and procedures that are involved. The personality of the individual is also important. This individual must have traits which are facilitative rather than controlling, and must be able to exercise authority without conveying an authoritarian attitude.

TRENDS FOR THE FUTURE

CORE STANDARDS AND PROCEDURES

One trend which is likely to be refined for the future is to formulate a single set of standards and procedures that can be used for many purposes, ranging from mental health and mental retardation programs to drug abuse and alcoholism programs—and from mandated items to optional items. There are presently too many sets of standards, too many monitoring groups and too much harrassment of operating programs by standards groups. Efforts are being made by the Psychiatric Facilities Council of the Joint Commission on the Accreditation of Hospitals to develop core standards. This is a commendable step. Also there is a need for commonly accepted procedures and acceptance by different agencies of all monitoring responsibilities centered in a single agency.

This will require careful planning and trusting collaboration by many groups, but something of this kind is essential in order to reduce the time and efforts consumed by operating programs in preparing for and being monitored by the many diverse groups to which they must be responsive.

GRADING AND MULTIPLE USES

Up to the present, most sets of standards have been used for single purposes. In the future it is likely that standards will be developed and monitored in such a way that the same overall set of standards can be used for multiple purposes. Thus, standards for each element will have several different levels stated in the standards document. A single set of monitors will measure the existing level of performance, and this basic monitoring information will be used for several purposes such as licensing, differential funding, developing plans of correction, staff development, etc.

There is likely to be grading of programs as well as graded levels in the standards themselves. The programs will be allowed to charge differential fees or will be funded differentially according to the grade level which they achieve. This will provide a mechanism for flexible rewards with an incentive for program improvement. There are only a few experimental standards programs of this kind at present.

CORRELATION OF QUALITY STANDARDS AND COSTS

A critical issue that will be addressed in the future is the correlation of quality standards and costs. Too often current standards are based almost exclusively on the concept of quality assurance with almost no concern for costs. Often the agency responsible for cost control is entirely separate from that responsible for quality standards. The most likely approach to cost control is then to deny payments for programs that are found to be out of compliance. This controls costs, but it sometimes forces programs out of business when the costs of bringing programs into compliance outweigh the benefits to be attained from the program.

Not all quality standards require additional funding, but many do—especially standards that relate to facilities and staffing. In a few instances standards will control costs by ruling out expensive or unnecessary procedures that lie outside the parameters of the standards.

One likely approach for the future is to tie the decisions about quality standards closer to the financing mechanisms. Standards will be reviewed by funding groups as well as by program professionals before they are approved and implemented. Another possible approach is to acknowledge that there are different levels of facilities and programs that will receive different levels of funding. This will be a difficult step for the mental health field which has tended to assume that there is only one acceptable level of care—and that is the finest. This concept has grown out of the private practice orientation of the private and academic sectors. However, it is doubtful whether our nation's resources are sufficient to espouse this philosophy for all services when the funding responsibilities will lie with taxpayers and third party payers.

Another possible approach is to establish cost standards. Cost standards have only rarely been used (i.e., "administrative costs shall not exceed x percent of the contract "), but they offer one possible way to control costs. They will pose tensions with quality standards in many cases, but they will put the burden on program managers to use the least costly procedures whenever possible.

OUTCOME STANDARDS

Another area of need for the future is the further development of outcome standards in the field of mental health. Because of the variability of outcomes in mental health and because so many factors influence outcomes other than just what the programs do (i.e., patient compliance, the economy, community attitudes), there has been reluctance to develop outcome standards. Thus, most existing standards in mental health (and all of the human services) are based on inputs and processes. The inference is that these standards will have an impact on service outcomes, but this is often a tenuous relationship at best. A few experimental efforts are underway to develop outcome measures based on social functioning as well as on purely psychological or psychiatric criteria. Much work remains to be done, but it is an area that must be given greater emphasis so that standards can be related more to outcomes than exclusively to inputs and processes.

CHAPTER 2

MANAGEMENT USES OF STANDARDS

State and federal mental health administrators have been slow to move into the development and use of standards. Until relatively recently there was little reason to do so. There was almost no agreement about what constituted quality standards for mental health care, and there was little advantage to having standards. No payment plans depended on standards. Furthermore, most mental health programs were under the direct operating authority of the state mental health agency.

There were also some negative features of standards that discouraged most mental health administrators from considering them very seriously:

> They were costly in a time when funds were short—especially if one tried to achieve quality standards.
>
> The notion of standards from industry carried the concept of standardization and uniformity which were not applicable to mental health.
>
> The idea of standards implied regulations of a controlling sort. Many mental health administrators had had unpleasant experiences with rigid licensing standards which may have been appropriate for restaurants or general hospitals, but which were firmly applied to mental health facilities as well.

All of these factors made mental health administrators reluctant to put their operating agencies into this kind of situation.

The past ten years has brought a huge expansion of funding of mental health programs and a dispersal of services to many community based programs where it is more difficult to provide administrative surveillance. The quality of programs and services thus tends to vary—some excellent and some questionable. There are wide variations in the costs and effectiveness of the same kinds of programs in different parts of the state.

The state level administrator needs some way of providing more specific program directions and assuring that the programs operate within those parameters. Standards are a possible mechanism for doing this. Standards also provide a certain assurance to patients, families and communities that the programs that serve them are functioning within defined limits. All of these factors, plus the greater public demand for accountability and the fact that third party payments are increasingly being tied to standards, are leading more and more state level mental health administrators to feel that state standards are both desirable and necessary.

While there are several broad objectives that may be achieved through the mechanism of standards, these objectives depend upon rather specific administrative uses of standards. The state mental health administrator who is contemplating the development of standards must be aware of all of the possible uses and decide which ones should be adopted by the agency. Standards may be used as a basis for:

Licensing, or otherwise authorizing programs to operate

Accrediting programs

Developing programs

Detecting and correcting deficiencies

Evaluating programs

Providing legal protection

Controlling costs

Allocating funds to programs

Assuring programs of fund entitlements

Defining program parameters

Reporting to the public regarding quality assurance

Standards are used as the basis for each of these functions in the following ways:

LICENSING, OR OTHERWISE AUTHORIZING PROGRAMS TO OPERATE

Standards are frequently used as the minimum measures of facilities or programs that shall be acceptable to allow the program to operate. This is most often done through the legal process of licensure. The minimum standards for licensure usually pertain to the protection of the life, safety and health of clients. Fire and life safety standards are only some of the standards that apply in the licensing process. Others include laundry practices, disposal of environmental and patient wastes and sources of air pollution. Programs that cannot meet the minimum standards are not allowed to operate or are closed down if they have previously been licensed.

ACCREDITING PROGRAMS

Standards also may be used as the measures for accrediting facilities or programs. Accreditation is usually a voluntary process which recognizes facilities or programs that have met certain standards at a level somewhat above the minimum standards required for licensure. There may be no advantage beyond being able to display a certificate as a badge of pride, but frequently this process carries other benefits. For example, accredited programs may be eligible to charge higher fees, or to receive certain payment benefits, or to conduct training programs—benefits which are not allowed to programs that are licensed but not accredited.

DEVELOPING PROGRAMS

Standards are often used as the measures for program managers to use in developing programs. This is particularly true of intermediate or optimal standards which become the program patterns for administrators to use in guiding their program activities. Standards help translate nebulous goals into specific requirements; used in this way, they are purely administrative directives. They have no special legal, regulatory or fiscal implications.

DEVELOPING STAFF

In a similar vein, standards may be used as the basis for training programs or for supervisors to use in their staff development activities. In a sense, the standards are used as textbooks on expected practices and quality for the training of staff who work in the programs. Standards may also be used for the education of board members, volunteers and funders.

DETECTING AND CORRECTING DEFICIENCIES

In many cases standards are monitored to detect areas in which programs or facilities may be falling outside of the expected measures so that plans of correction can be developed enabling the programs to achieve compliance with the standards. The standards are then used much like a thermostat which regularly monitors the room temperature and takes appropriate corrective action to keep the room comfortable when the temperature goes above or below the predetermined measures.

EVALUATING PROGRAMS

Standards may be used as a program evaluation device to determine how the programs are functioning compared to the standards—where they are overachieving, underachieving or otherwise deviating from the standards. These determinations may then be used for reordering programs, deciding on new programs or requesting new resources.

PROVIDING LEGAL PROTECTION

Standards may be used as a means to lessen the threat of law suits or to defend any suits that may arise. The standards are offered as evidence that the program or facility meets certain procedures and characteristics which are generally deemed to represent adequate levels of care. Standards may also protect the program from charges that it acted in arbitrary or capricious fashion since each standard is specified in writing and is applied equitably across the whole mental health system. The state also demonstrates its concern for individual rights by having appropriate standards related to privacy, confidentiality, permission for treatment, etc.

The state or local agency which can demonstrate that it is in compliance with standards may lessen its chances of being sued in individual or class action suits and may strengthen the defense of any suits that may be filed. On the other hand, programs which are not in compliance may thereby increase their liability. It must be cautioned that having standards which are regularly monitored and met does not guarantee that there will be no suits. It simply lessens the likelihood. In a rare instance, such standards might provoke a suit if an advocacy group is seeking notoriety and feels that publicity might be gained by suing a program which maintains especially high standards.

CONTROLLING COSTS

There is considerable rhetoric about using standards to control costs by refusing to make payments for services rendered in programs that do not meet the standards or by not paying for services that lie outside the parameters of the standards. In fact, standards that assure high quality care are, paradoxically, likely to increase costs. In a few places there are cost standards (i.e., standards for overhead costs or standards for administrative costs), but these are presently rather rare.

ALLOCATING FUNDS TO PROGRAMS

It is possible to use standards—and the extent to which programs meet standards—as criteria for the allocation of funds. This may be done by allocating funds only to programs that meet standards, or by assigning higher levels of funding to programs that meet higher standards, or by allocating funds to programs that do not meet the standards in order to help them come into compliance.

ASSURING PROGRAMS OF FUND ENTITLEMENTS

The state agency may use appropriate standards and monitoring procedures to assure that the operating programs for which it has responsibility are in compliance to receive funds to which they are entitled under various third party payment plans, including federal payment programs. Similarly, standards may serve to reassure local funding groups such as county commissioners that the programs they support are of acceptable quality although these may not be entitlement programs in the usual sense.

DEFINING PROGRAM PARAMETERS

Standards may be used as the basis for defining the parameters of acceptable clinical practices, facility use or personnel management and limiting extreme variations. This is somewhat kin to the process of standardization in industry, but it is usually less drastic. Standards provide the descriptions of acceptable procedures and techniques and require any programs that deviate to document and justify their practices or to cease them.

REPORTING TO THE PUBLIC REGARDING QUALITY ASSURANCE

A major use of standards is to have a mechanism to assure the public through reports, certificates, etc. of the quality of the programs which are available. This may be done through certificates or plaques displayed in prominent areas, through publicity in the media, in brochures and in annual reports which announce that specific programs are in compliance with the standards. The clients and families and their referral agents then have reasonable assurances of the quality of programs. The public expects and deserves to know that standards are clearly written, monitored regularly, and that plans of correction are implemented to remedy any deficiencies.

FACILITATION VERSUS CONTROL

It is apparent that some of these uses of standards are inherently more authoritarian than others. Some administrators will lean to the mandatory and regulatory uses while others will more likely choose the facilitative and developmental uses depending on their own personalities and administrative styles.

These several uses of standards are not incompatible with each other, but they must be carefully planned, because the standards will probably be developed, worded and monitored differently depending on which uses are to be made of them.

Initially, standards in mental health were purely voluntary as used by either the old Central Inspection Board of the American Psychiatric Association or by the Psychiatric Facilities Council of the Joint Commission on the Accreditation of Hospitals for voluntary accreditation. Some states later formulated optimal standards to be used as guidelines for the development of various kinds of programs.

In recent years, however, the use of standards has become more associated with the concept of regulation. This regulative trend is manifested by the use of such terms as "minimum standards," "assuring compliance," "licensure," and "cost control." It is unfortunate that this coercive aspect of standards has become so prominent in everyone's mind, for it is perhaps the least productive use of standards. The facilitative uses of standards as guides for program development, staff development and accreditation offer far more promise for achieving compliance than do the regulatory uses. The carrot remains a better motivator of behavior change than the stick.

Yet most standards have certain minimum regulatory aspects as well as facilitative aspects. Thus, standards programs often function much like the police department which has a primary role of facilitating our society by directing traffic, helping children and old people, etc., but it also has a social control function of arresting violators. Because the social control function is so dramatic, there is a tendency for the police department to be perceived primarily as a control agency although the control functions comprise only a small portion of the work. Similarly the standards process is likely to be viewed as a control function rather than as a facilitating function unless this issue is carefully addressed.

In most cases the state mental health administrator will want to use the standards as a management tool for directing the state's mental health programs toward improved performance rather than primarily to help them conform to the standards of outside groups, or just to control costs. If this is so, the administrator will be primarily interested in helping the programs to come into compliance with quality standards rather than in cutting off funds, revoking licenses, or taking other kinds of harsh administrative actions. The administrator must take great care in how a program of standards is announced, developed and used.

The administrator will want to make it quite clear in announcing a standards program that it is primarily an effort to facilitate program development and direction rather than a control mechanism. Then the administrator must be careful about the persons and processes that are chosen to administer the standards program and how the standards are ultimately worded and used. If the standards are frequently used in punitive ways, it will readily confirm the suspicions of the operating program that the standards program is a control mechanism after all.

It is preferable to develop a system of incentives and rewards based on improved standards performance. Among the incentives that might be used administratively to motivate programs are extra funds, certificates, public awards, special recognition in the media, letters of commendation and higher grades.

Because the standards process is so dependent upon the values and attitudes of the leaders of the programs, it is especially important that the philosophies and values of the administrator be articulated in the introduction to any standards document. This matter of different value systems is probably the source of more conflicts in the interpretation and uses of standards than any other issue. The measures by themselves are clear, but differing philosophies will cause them to be interpreted very differently.

There are ways to combine several kinds and uses of standards into a single standards setting and monitoring process. There is relatively little experience with this kind of combination, although there are some examples. Thus, for example, some standards have included two levels of standards for several items, one entitled "essential" and the other "recommended."

There might be three or more levels within a single element of standards, each of which would be used for a different purpose. An example of such levels relating to a standard for clinical records might be:

> A clinical record of history, diagnosis and treatment will be maintained for every patient. (mandatory)
>
> An organized and bound clinical record of the history, diagnosis, treatment and progress shall be maintained for each client. This record will include signed laboratory, x-ray and consultation reports that are readily identifiable. (intermediate for special funding)
>
> The clinical record system of choice is an individualized, goal-oriented clinical record which contains the data base, a problem list and treatment plan and has all of the treatment and progress notes coded to the appropriate goal. (optimal)

The surveyors would record the appropriate level of development of each program's clinical records, and the results would be used for the appropriate actions.

Some human service systems, such as the New York State Nursing Home Authority, are experimenting with a grading system based on such standards. Each nursing home will be scored so that some will barely pass while others will make the honor roll.

ADMINISTRATION TO ATTAIN COMPLIANCE

Since for most administrators the major objective will be to attain maximum compliance, it may be well to examine the steps that tend to lead to the greatest achievement of compliance. Among them are:

Involve the persons to whom the standards will apply in developing the items and the measures.

Announce the standards, deadlines, procedures, etc. clearly in writing.

Provide the reasons for the standards and any guides for interpretation.

Provide on-site surveys by a team of specialists when possible. Single surveyors are likely to be suspected of bias, but people much prefer to be visited rather than to be judged by paper forms that they have filled out and sent away.

Make the survey as colleagual as possible and have the report focus on strengths, weaknesses and recommendations. This basic report should be given to the program leaders before the survey team leaves the site.

Have written reports of survey findings and recommendations follow as soon as possible after the visit.

Have surveyors inquire as specifically as possible about items not in compliance. Do not gloss over these areas or be unduly harsh.

Accept "substantial compliance" rather than literal compliance when feasible.

Have the program prepare a plan of correction for any deficiencies with datelines.

Insist on early correction of deficiencies which require little expense. Be reasonable about items that are more costly.

Give notice of uncorrected deficiencies and schedule actions in writing, but do not make them public.

After full and fair warning in writing, take the promised action—again in writing and in private when possible.

Involve the programs to be affected in the review and modification of standards, procedures and uses.

These general principles provide for maximum input, flexibility and fairness. Not all steps are universally applicable in all situations, but the administrator should strive to set as many of these steps as are feasible.

QUALITY ASSURANCE VERSUS COST CONTROL

A few words need to be said about the uses of standards for quality assurance versus control of costs. In many ways these are contradictory objectives because higher quality of programming is likely to cost more money. Of course, there are many procedures (i.e., having an individualized treatment plan for each client) which assure a higher quality of programming and which do not necessarily cost money. These items should be given a high priority for compliance in a standards program. These include record-keeping procedures, procedures for assuring privacy and confidentiality and many quality-of-life standards.

However, there are many other items, especially input standards related to facilities and staffing which are likely to cost considerable money. The administrator who sets high standards in these areas must be prepared to expect higher costs. Mechanisms for higher payment will have to be linked to the attainment of these standards or the operating agencies will be forced out of business. It may be possible for the administrator to waive the full attainment of such costly standards provided that progress is being made toward reaching them and provided that they are not items that are critical to life safety.

The matter of containing costs through the use of standards is usually managed by simply refusing payments to programs that do not meet the standards. This, of course, does not raise the quality of the service; it denies payment for the services. This is likely to force the program out of business. In some cases this may be a desirable outcome, but there are many rural areas and inner city neighborhoods where closing out such programs leaves the population with no services at all. The administrator is then faced with the decision of whether no service at all is better than services that do not meet the standards.

In the matter of standards for cost control there has been little attention to the use of cost standards for differential levels of care. Our society has tended to assume that there is only one acceptable level of care in mental health, and this is the very best. Perhaps society needs to explore the possibility of different (but still adequate) levels of mental health care, just as society accepts different levels of quality and costs in housing, clothing, automobiles and other hard goods. To some extent this notion exists in regard to graded levels of nursing home care, but it has been given little systematic attention in the overall field of mental health.

RELATIONS BETWEEN MANAGEMENT AND STANDARDS

Once the decision has been made to implement a program of standards, it becomes the responsibility of the administrator to announce the program, including its philosophies and uses, and to select a staff and organize them to do the job. The announcement and the selection of staff in many ways set the tone and the acceptance of the program by the rest of the management team and throughout the entire agency.

The matter of who is selected and how this person is supervised deserves special attention by the administrator. The person selected must be a good administrator, but also must have a personality suited to facilitation rather than to control.

The administrator of the agency will do well to assure that the person selected is oriented to the desired philosophies both for the overall program operations and for the standards program itself. This will require close supervision in the early stages of the development and monitoring of the standards program. Special attention should be given to any problems or controversies that arise early in the program so that they are quickly resolved and not allowed to fester along to jeopardize the usefulness of the standards. Regardless of how well the standards program is run, there will undoubtedly be some problems. There nearly always are problems in any program, and they usually reveal themselves before the benefits of the program become apparent. It is well to be alert to these and to take early action on them.

Once the standards program is in operation, it is the administrator and the management team who take the actions to make administrative uses of the standards. The standards staff report their findings to the administrator and to others on the management team at both state and local levels, but the evaluation of these findings and the decisions for action lie with management. In some cases, the standards office may be delegated responsibility for assuring compliance and developing plans for correction of certain items. However, the decisions about licensing, funding, accreditation, program change, staff development, etc. lie with the administrator and with others on the management team.

Thus it is essential that the standards office have a relationship to management that encourages the standards office to report its findings in a useable fashion to management and that expects management to report back to the standards office on what actions have been taken or what uses have been made of the reports. This means that the necessary findings will be extracted and presented to management in a concise and readable form. The standards report may make recommendations or offer interpretations of the findings for management, but these recommendations should be separated from the report of findings themselves.

One question that arises is whether to involve persons from outside the state mental health agency and its operating programs in the standards process—especially in the monitoring process. In several places there have been representatives from professional associations or from citizen advocacy groups such as the mental health associations involved in the development of standards. If this is done, care must be exercised that these persons are working for truly meaningful standards and not just for protection of their professional turf. Obviously the decision about whether to involve such groups is made by management, and the initial invitations to participate are extended by the administrator.

Having such persons involved in the monitoring process is a somewhat different matter, and this is less commonly done. Having persons from the professional associations on the survey team lends itself to a kind of cronyism in which the professionals may attempt to use the standards monitoring to advance their professional colleagues and values in the eyes of management. This can be avoided, but it is a tendency that must be watched.

The use of a person from citizen advocate groups on the survey team has much to recommend it. It adds credibility to the standards process, it facilitates communication with these groups, and it adds valuable lay citizen perspectives and insights. These persons should have training in the survey process, much like that for other survey visitors, but they can be very useful to the administrative process. Obviously these are decisions to be made by the administrator, and the administrator should negotiate the original contacts for such arrangements.

It is also the responsibility of the administrator to see to it that the standards themselves and the overall standards process are periodically evaluated and modified in appropriate ways. Some standards turn out to be of little use; others need to be upgraded; new technology and new social values require the establishment of new standards or the modification of old standards. There is a tendency for the standards office, like any other office, to expand and elaborate its functions. This tendency should be watched very carefully. There are surely ways in which the standards and the procedures for monitoring and using them can be refined and improved, but there is also considerable virtue in keeping the overall standards process rather simple and flexible. It should be relatively unobtrusive. It is the job of management to help the standards operation to be as effective as possible in the management process while providing the least possible burden on the operations.

CHAPTER 3

CONCEPTUAL ISSUES IN STANDARDS

This chapter and this publication present some of the concepts and information about standards which it is hoped states will find useful as they make their decisions about whether to have standards and what kinds to have. It does not prescribe any particular model or concept on which states should base their standards programs. It cannot give absolute answers to many questions which the states may have because the organization, size and programs of the state mental health agencies vary so greatly that it is not possible to provide blanket answers. However, there are some common issues and some common alternatives which any state will want to consider as it makes its decisions.

There is little overall consistency in the terminology and philosophies regarding standards, and the same words and concepts often mean different things to different people. Many of the concepts have come from the standardization activities of industry, and are equally appropriate for the human services area, but there are some substantial differences, a major one being that industry is able to standardize its products while the human services have not yet been able to accomplish this. The mental health program administrator and the standards developers need a clear understanding of the conceptual issues before they undertake a standards program.

Many states have focused their attention on qualifying their operating facilities (e.g., state mental hospitals and institutions for the mentally retarded) under the accreditation standards or regulations of some other organization. In response to public demand for quality assurance and cost control, many state mental health agencies are now setting and monitoring standards for their own institutions and for community mental health facilities and programs for which the state has some surveillance responsibilities, such as community mental health centers or alcohol and drug abuse programs. (See Appendix B, Survey of Standards Development and Use in State Mental Health Agencies of the South.)

As the state mental health agency contemplates developing and monitoring its own set of standards, it is likely to make a somewhat different use of standards. Rather than simply helping its field operations to come into compliance with the standards of other organizations, it will now use standards as a tool for more effective management of the programs for which it has operating or surveillance responsibility. As mental health programs have become dispersed to dozens of community operations rather than being centralized in a few large institutions, it has become more difficult to provide direction and control for the programs. Standards give promise of being a management tool for giving direction and guidance to dispersed programs. In addition, they offer a way to have specific data about program operations in order to report back to patients and families, third party payers, state officials and to the public at large with the assurance that programs are providing adequate care for the funds being spent. This is a major element of the present day clamor for accountability. Standards also offer a mechanism for evaluating programs and determining staff development needs.

WHAT IS A STANDARD?

The definition of terms in mental health standards is confusing. It is not unusual to find several words being used to refer to the same thing or to find that a single word has a variety of different meanings. The foundation of a standards program relies on the clear definition of terms to build a unified, cohesive base on which to construct the standards process. Sharply defined terms serve as a point of reference to help improve communications between standards personnel and mental health clinicians and administrators. While ecouraging creative discussion and interaction by providing a way for persons to better understand each other, common definitions also help reduce the chance of misunderstandings and confusion. Through the use of a common language, standards further increase reliability and objectivity of judgments and observations made about a program being evaluated, since each evaluator is using the terms according to common definitions.

In this publication, a *standard* is defined as *a statement describing the level of specification or performance against which one can measure physical plant, individual effort, functional activities or organizational achievement.* A standard may be used to judge capacity, quantity, content, quality, extent, value, etc., of program operations or the facilities within which programs operate.

Some of the terms which have been confused with standards are "rules and regulations," "policies and procedures," and "guidelines." As defined above, standards are simply measuring devices. The confusion with other terms arises when standards are used for purposes other than assessment. To illuminate some of the confusion, this section examines the relationship of standards to these other terms, which are elements within a possible theoretical chain of command dealing with governance.[1]

The theoretical model of governance in a state agency includes a hierarchy of mandates (e.g., legislation and court rulings), formal rules and regulations, policies and procedures, orders and instructions, customs and styles. Through this theoretical hierarchy the agency exercises its power to direct and control the programs for which it has responsibility. In this model the greatest legal power rests with the mandates of the legislatures (Congress or the state legislatures) and with court rulings, while the least power rests with customs and styles. In this hierarchy, mandates overrule regulations which in turn supersede policies, directives, customs and styles in that general order. It is in the middle rungs of this hierarchical ladder (regulations, policies and directives) that standards are most often used.

Formal regulations are part of the process of administrative law and are designed to ensure that specific legislation is put into effect. They are usually generated at the level of the organization which is expected to enforce them, and once filed with the appropriate office and published in a public register, have the force of law. Most formal regulations are statements of specific requirements that are applied to the programs to be directed. For example, the federal regulations regarding federally funded community mental health centers require the reporting of certain data regarding the center's services, staffing and expenditures. There is no standard in such a regulation. However, there are some cases in which a regulation includes a set of standards by which the programs are to be measured. For example, a regulation may set forth ratios for staffing. Confusion then results when people refer to that set of regulations as "standards." There is also a tendency for some persons to refer to any requirements—whether in law or in regulations—as "standards." This is not a proper use of the word, although it is common in everyday use.

Below the level of formal regulations, most agencies have policies and procedures manuals. Policies are broad statements of philosophies about programs and are chosen from among various alternatives; procedures are the statements of specific activities or processes to implement them. For example, a policy might state the agency's position that all formally admitted patients shall have a complete physical, psychological and social work-up. The procedures would then prescribe the specific steps to be taken by programs to fulfill that policy. Most policy and procedure manuals do not contain standards, but occasionally a procedure includes a set of standards by which the procedures will be measured.

The state agency also usually has a series of administrative directives or orders which apply to the programs for which it has responsibility. These are not formally issued through the state's machinery for formal rules and regulations. They are internal instructions or orders which the agency uses to direct and control its own programs and those at the community level for which it has some responsibility. These directives also do not usually contain standards, but they *may* have a set of standards by which the activities are to be measured.

In addition, many state agencies issue guidelines for various aspects of programs. Guidelines offer suggestions, alternatives and broad parameters to guide program and staff development. Even in their more restrictive use, they simply set boundaries.

They, too, may occasionally include a set of ideal standards for measurement of a particular aspect of programming. However, they are not prescriptive in the sense of regulations, procedures and directives. In all of these instances, it is not really appropriate to refer to the overall procedures, directives or guidelines as "standards," but this is a common point of confusion. It might be more appropriate to refer to all of these combinations of elements as regulations, procedures or guidelines *which contain standards.*

VALUES AND PHILOSOPHICAL ORIENTATIONS

The values and philosophical orientations of the mental health agency and its programs are crucial in the process of developing and monitoring standards. These value orientations, which may be derived from the mental health professions, society, advocacy organizations or leaders of the mental health agency itself, underlie both programs and standards from their conception through their use.

Basic to any program are certain philosophical beliefs about the nature of the problem it is addressing. For example, a mental health treatment program may follow a medical-psychiatric model because of a belief that mental disability is a behavioral disorder rather than a medical illness. Philosophical orientations also influence the extent to which a program sees its goal as restoring the mentally disturbed to social functioning or simply removing or repressing their psychopathology.

The philosophies upon which programs rest often are held implicitly rather than being made explicit. The standards program should attempt to make these philosophies explicit before standards are developed. Without explicit philosophies, the measures set in standards may be interpreted in various ways by surveyors or other persons who are operating with differing implicit philosophies.

SOURCES OF STANDARDS

Philosophy also determines whether the standards themselves are derived from theoretical grounds or on empirical grounds. Standards which rest on theoretical grounds are those which are based on reasoned criteria of what are believed to be desirable qualities of a program, but without reference to any external criteria or norms. An example is that there shall be individual stalls for privacy in toilet rooms and in shower rooms. Most mental health standards that relate to the quality-of-life and confidentiality are based on this kind of theoretical judgment of what is desirable without any reference to statistical norms from other similar programs. The criteria measures for theoretical standards are often based on the simple demonstration that certain procedures or characteristics exist in the program or facility. The criteria are then answered by a simple "yes" or "no" answer rather than by quantitative measures of "how much."

Standards which are empirically oriented are those which are primarily based on data gathered through experimentation and observation and systematic comparison of the characteristics or performance of similar individuals, programs or organizations. For example, standards for drug programs might employ norms derived from the performance or characteristics of a sample of drug programs which were judged to provide quality treatment. The word "norm" is frequently used in relation to empirically based standards. Norms generally imply statistical averages (mean, median, mode), which have been derived from larger statistical populations. This norm is used in the standard as a reference point against which individual persons, programs or elements are judged. Standards based on empirical norms are likely to require numerical measures that can be used for comparison with the statistical norms.

Many standards are not based solely on either empirical or theoretical data, but combine the two types. The use of either kind of standard is dependent upon the goals and objectives toward which a program is striving. However, while standards may be related to goals and objectives, they should not be confused as being the same thing. Standards are the measures of acceptable parameters for the facilities and program processes that will be required in order to achieve the goals and objectives.

In the realm of industry, standards clearly specify and put into action the objectives of a program and make them measurable and observable. These standards are likely to be set in terms of a product or a service which is the output or outcome of the industry. Such standards are easier to set in industries which produce a measurable physical product than in human service fields such as mental health where outcomes are more difficult to specify and measure. Thus, standards in mental health are more likely to focus on inputs and processes of treatment which are believed to be related to a program's intended goals and objectives. Where possible, standards should specify acceptable levels of performance. Once standards are in tune with objectives and have been made workable, they can help focus a program's efforts and provide a means of measuring its performance and progress toward its objectives. Used in this way, standards become a potent administrative tool for program guidance and evaluation.

STANDARDS FOR WHAT?

Standards serve certain broad purposes when applied to mental health programs. Among the purposes are:

> *To assure the health and safety of clients.* This is usually the purpose of fire and life safety standards which are applied to facilities. These standards are likely to be mandatory items in any set of standards.
>
> *To assure an adequate level of care and treatment for clients.* This is the purpose of professional standards (i.e., those of professional review organizations).

> *To assure that certain basic rights of clients are observed.* This is the purpose of standards related to the quality-of-life, privacy, confidentiality of records, least restrictive alternatives for care and individualized treatment plans. Such standards are developing under pressure from court suits and advocacy groups. They are controversial, and they can be expected to receive much more attention in the future.
>
> *To assure the public and support groups that there is an appropriate quality of programming for their support.* This is the purpose of standards related to the structure of administrative boards, accounting procedures and staff development. It is also the purpose of many program and facility standards.

These are broad purposes of standards which relate to the ways the standards serve clients, families and the public to assure that programs are operating at satisfactory levels. Agencies then translate these broad purposes into specific administrative use of standards. The agencies which make specific use of standards may be federal agencies, such as those of the Department of Health, Education, and Welfare; national voluntary agencies, such as the Joint Commission on Accreditation of Hospitals; or state agencies, such as departments of mental health or health.

The variety of administrative uses to which mental health standards may be put includes:

Licensing of programs or facilities

Accrediting of programs or facilities

Program development

Staff development

Program monitoring to achieve compliance

Program evaluation

Control of costs

Control of activities which lie outside of the parameters of good care

Allocation of funds

Assuring programs of fund entitlements

Reporting to the public regarding quality assurance

More has been said about each of these in the previous chapter on Management Uses of Standards. For now, it is sufficient to list the full variety and to suggest that every standard should be accompanied by a statement of why the standard was developed, the ways in which it will affect the quality of care, how it will be used, and how it might be interpreted. According to Humble, the identification of the specific uses to be made of a standard will determine the attributes to be emphasized in its design.[2] For example, if a standard is to be used to contain costs, the standard should spell out the critical cost variables to be examined and measured, and the effects that should appear in the monitoring data if the standard is applied.

STANDARDS AND QUALITY

Finding a universally acceptable definition of "quality" seems almost impossible—even to industry which generally produces more measurable products than does a mental health agency. Webster's *New World Dictionary* defines quality as "the degree of excellence which a thing possesses." However, excellence is as slippery to define as is quality since excellence is a purely comparative term meaning "to be better or greater than." The Department of Health, Education, and Welfare *Plan for Health FY1977-81* states that "quality health care offers the patient the greatest achievable health benefit, with minimum unnecessary risk and use of resources, and in a manner satisfactory to the patient."[3] This statement recognizes four factors in determining quality: effectiveness, patient safety, patient satisfaction and cost. Quality control is the activity of managing these so that the quality is maintained or improved. Quality assurance is the process set up to assure that the procedures needed to maintain or improve the quality of the programs are being carried out. Present day concepts of quality assurance require the disseminating to key persons and agencies information on how well the procedures are being followed, as well as simply assuring that they are being met. Briefly, quality control is making quality what it should be; quality assurance is making sure that the resulting quality is what it claims to be.

The classical notions of a delivery system involve three components: inputs, processes and outcomes, none of which alone can be considered an adequate measure of quality. Input standards focus on the characteristics of the resources (staffing, facilities, equipment and funding) which are presumed to be necessary to assure a certain quality in a program. The philosophy behind measures of input is that better quality of care is more likely when there are more and better qualified staff and improved physical facilities in a program. Older standards were almost entirely based on inputs, but there is a tendency today to give less emphasis to inputs and relatively more stress on process.

Process standards are the clinical and administrative procedures which are presumed to assure a certain level of service. Examples are: "A physical examination of all patients shall be performed by a physician within 24 hours of admission." Or "All medications shall be given and recorded under the supervision of a registered nurse." The focus on the process component assumes that there will be quality service when there are sound fiscal, administrative and clinical practices. Many persons feel that the processes are more closely related to quality than are inputs.

Outcome standards are the measures of the final results of the programs. The outcomes are produced by the interaction of inputs and processes and would seem to be the ultimate test of quality.

Unlike industry where the output is an inert product, there is not much consensus about what constitutes a satisfactory outcome in mental health. Much of the result depends on what the client or patient does to cooperate and help in the process.

In the case of a mental health program, it would be more appropriate to judge outcomes of groups of patients rather than of individuals, since there will inevitably be some patients who do not attain a desirable outcome yet cannot be recycled or rejected like a product of the assembly line.

While it may ultimately be desirable to focus mental health standards on outcomes, much more work is needed to achieve consensus of what might be acceptable standards for outcome of most mental health conditions. Thus the present tendency is to focus mental health standards on the inputs and the processes.

LEVELS OF STANDARDS

Another dimension of standards which requires consideration is the level of quality which they address. The levels may be set in several tiers. In general, standards for any particular aspect of a program may be described in three levels:

> *Mandatory or essential.* This is the level of standard for a program or facility which is considered basic to the program's operation. These may be the basic standards for licensure. If the facility or program falls below these standards, it will be ordered to cease operation.
>
> *Intermediate.* These are the levels of standards that represent a quality of facilities and programming beyond that which is basic for operation. There may be several intermediate levels of standards (i.e., for class A and class AA programs). These intermediate levels are used for such activities as accreditation, differential funding and other special recognition.

Optimal. These are standards for programs that express what is felt to be ideal within the limits of present knowledge. These ideal standards are most often in the nature of guidelines which are used as goals for program and staff development.

While these differential levels are implicit in most sets of standards, they are seldom specified in the overall standards document. There is by no means universal agreement on this terminology, but the concepts are nevertheless present. In fact, there is a tendency to refer to any standards as "minimum" for the use to which they are to be put, even though they are not minimum in the sense that they are mandatory or essential for the program's operation.

To some extent the levels represent stages in the development of standards, but they are more likely to represent different levels of quality in the programs themselves and the resources available. An example of levels might be:

Mandatory or essential. There shall be a written clinical record maintained on each patient.

Intermediate. There shall be a bound clinical record on each patient showing identifying information, medical and social history data, diagnostic evaluations, treatment orders and progress notes.

Optimal. There shall be a clinical record maintained on each patient showing an individualized treatment plan and progress notes related to the attainment of that plan.

While it is presently somewhat unusual for a set of standards to address two or three levels of quality, it is quite possible to write standards in such a way that they identify more than just one level. Thus a set of standards might have the basic items set forth in capital letters. The monitors would then be sure that those items were met for all programs. Intermediate and optimal standards might be written in lower case letters so that the surveyor would measure them and judge the appropriate intermediate or optimal level of program which is found to exist. Such a single set of standards which incorporates all levels of measures might simplify the whole monitoring process so that one survey visit could suffice for several uses. More work needs to be done before such a pattern becomes widely operational.

ELEMENTS TO WHICH STANDARDS ARE COMMONLY APPLIED

Standards may be applied to many elements of a mental health program. Among the elements to which standards are commonly applied are:

> *Facilities.* These standards deal with the physical plant, buildings and equipment. These are the standards that speak to space requirements, fire protection and other life safety items.
>
> *Programs.* These apply to the overall programs such as community mental health programs, alcohol treatment programs or children's programs. They include attention to needs assessment, admission and patient movement procedures, staffing and program evaluation.
>
> *Administrative services.* These apply to the administrative organization and include standards for operating boards, advisory boards, staff organization, accounting and personnel procedures.
>
> *Professional or clinical services.* These standards apply to the specifics of diagnosis and treatment. They include all of the matters that Professional Standards Review Organizations address.

Support services. These standards deal with program support activities such as clinical records, pharmacy and volunteer services.

Another major element of standards that is rapidly emerging is what might be called "patient rights" or "quality-of-life" standards which include such matters as confidentiality, privacy, dignity, least restrictive alternatives for care, etc. They are developing under pressures from court suits and advocacy groups.

FOOTNOTES FOR CHAPTER 3

1. Theoretical typologies can be useful conceptual tools; however, there is always the possibility of creating artificial distinctions between items and forcing some of the elements within them into what may be unnatural relationships.

2. Thomas N. Humble, *Standards in Strategic Planning and Control*, (Austin, Texas: The University of Texas, Bureau of Business Research, 1966). P. 38.

3. U.S. Department of Health, Education and Welfare, Public Health Service, *Forward Plan for Health: FY 1977-81* (Washington, D.C.: August, 1975). P. 142.

CHAPTER 4

DEVELOPING STANDARDS

Many states are or will be developing standards because they have determined that it is desirable for their mental health program or because they have been required to do so by third party payers, federal agencies or their state legislatures. This chapter looks at the process of developing state level mental health standards to be used as management tools in guiding or directing programs and in evaluating progress.

Traditionally, the delivery of mental hospital and institutional services for the mentally retarded has been the responsibility of the states. With the development of community mental health services and the growth of services for alcoholics and drug abusers, there is an even larger investment of state resources over which the state attempts to maintain some control. Since many of these newer services are not direct state operations, they are not subject to all of the usual administrative directives. However, standards of various kinds provide one mechanism for keeping some administrative control over quality and costs of all of these programs—both those for which the state has direct operating responsibility and those for which it has some financing and surveillance responsibility. These standards may be in the form of formal regulations or in less official administrative procedures, directives or guidelines.

Mental health programs vary widely, but in standards development and use they share a common need for a strong and committed management. It is important for the manager to think through the entire process and the uses to which the standards will be put before taking action. There are many implications and ramifications of each step—the choice of items for which to set standards, the wording of standards, the measures, the monitoring procedures, etc.

The development of a standards program in many ways reflects the basic development of the mental health program itself; standards provide for greater specificity than that which is initially built into programs. In most mental health programs the objectives and goals are stated in only the broadest and most general terms in their enabling legislation or in their administrative authorization. It then becomes the responsibility of leaders in the agencies to define more specific objectives and goals and to disseminate them throughout the agency and to related persons in the communities.

This step often lacks the kind of precision that might be desired. However, when the administrator decides to develop a standards program, it will be necessary to be very specific about the goals, objectives and procedures in order to write the standards by which the programs will be measured. Once the standards have been set, it will be relatively easy to monitor the results and to make plans for any corrections that may be needed. Standards are the measures of performance that are used to guide programs and to feed back information on how well the programs are functioning compared to the way they were intended to function. Just as there is a need for programs to be periodically reviewed and modified, so there is need for the standards to be periodically reviewed and changed. Some will be discarded; others will be added to or made more specific.

THE PROCESS OF STANDARD SETTING

The development of standards is an evolutionary process in two ways: 1) the standards progress with the further refinement of the program they guide, and 2) the standards program itself is refined after a period of experience and evaluation. "States have found that it is both counterproductive and impossible to try to develop a final, comprehensive set of standards on the first attempt."[1] Standards develop in gradual increments which initially address only a minimal number of essential elements. At all times efforts should be made to limit the standards to the significant aspects of programs and to only the critical measures of those elements. It is easy for a standards program to become so burdensome that it loses its impact by including standards related to a host of relatively insignificant aspects of mental health facilities and programs.

Within the Southern region, the states reported that it took from three to twelve months to develop their initial standards. This time required for developing standards was influenced in part by the stage of development of the service delivery programs and in part by the resources which were available for setting standards.[2] Additional time was frequently needed for field testing. The Accreditation Council for Psychiatric Facilities of the Joint Commission on the Accreditation of Hospitals took two years to plan, write and field test its standards. A number of international studies done by industry indicate that the average length of time from initiation to promulgation of industrial standards was approximately three to four years.[3]

The setting of standards involves three conceptual developmental stages: planning, writing and promulgation.

PLANNING

The most basic of all questions in regard to standards is *whether to write any state level standards at all.* There are many existing sets of standards related to various aspects of mental health programs. These have been developed by various national and federal organizations for their own rather specific uses (i.e., voluntary accreditation, special funding, etc.) which often do not fit well with all of the needs of a state mental health program. Some of them may actually be inappropriate in certain states or in certain parts of the state. Thus a state may feel that it is desirable to develop its own set of standards which will be comprehensive and appropriate for its own program uses. This may be done by adopting other sets of standards when they are to apply. Even then care must be exercised to assure that the state is not being burdened with inapplicable standards or unsuspected future problems. The Occupational Safety and Health Administration (OSHA) adopted wholesale standards in this manner and inherited numerous "time bombs" which were not evident at the time they were referenced.[4] Each program, region and state has particular needs which standards should be tailored to address.

Because of the difficulties in developing and monitoring universally acceptable standards in mental health, most state mental health agencies and the federal agencies concerned with mental health have been reticent to move into this area in the past. In recent years pressures from third party payers, from court suits and from Congress are moving both state and federal agencies closer to requiring standards as part of their regulatory mechanisms. For example, the 1967 amendments to the Community Mental Health Centers Act of 1963 required that the states include in their plans provisions for the enactment of standards for the maintenance and operation of community mental health centers. In 1974 Congress amended this law in PL94-63 to require the National Institute of Mental Health to report to Congress on the development of national standards for the quality of care in the centers. At this time it is not certain whether NIMH will set such national standards or whether it will accept state standards, where they exist, as being in accord with Congressional intent in lieu of overall federal standards. The rest of this discussion follows the assumption that the states and their mental health agencies will prefer to set and monitor standards for themselves.

The political and administrative climate has determined that standards are necessary. By taking the initiative, managers may turn the standards process to their own programs' advantage rather than having it imposed and monitored from the outside. Since standards generally emanate from management, the first step in the process of developing standards will usually be a *declaration of support for standards* by management. According to Humble, this top-level backing should include "the belief in, and the cultivation of the concept that continuous adaptation, improvement and refinement of standards of performance are essential to the operating effectiveness of planning and control."[5]

In the early stages of developing standards, the state must ascertain what standards already exist that impinge on mental health operations. The state mental health agency needs to know where these other standards originated (i.e., a federal agency such as NIMH or a national agency such as the Joint Commission on Accreditation of Hospitals or another state agency or local governments), what type they are, and how the standards impact on the state mental health agency's programs. The state mental health agency must construct its standards so that they do not substantially conflict with those already in existence. At times the agency may incorporate existing standards into those it develops and then build in greater specificity or include additional items not covered in the existing standards.

Not only should the state mental health agency know what federal or national standards might affect state standard setting, but it must also discover what pertinent standards apply within the state itself. These are particularly likely to be found in the standards of the state health department or in those of the state fire marshal. Local standards frequently take the form of legal codes which spell out certain life safety, fire and building construction standards. Often the mental health programs are required to be licensed by other state or local agencies according to their standards. In these instances the mental health agency may wish to simply adopt the standards of the other agency for these aspects of their programs with whatever refinements or additions the mental health agency feels should be made. However, there should be no major conflict between the standards of the mental health agency and the standards of other agencies. Such conflicts would put the operating program to which the standards are applied in the untenable position of being out of compliance with one or the other of the standards. In any such area of conflict there must be a statement of which set of standards shall prevail.

There are two other early steps in standards development: 1) a rather detailed *description of operating practices*, and 2) an *inventory of existing and expected program resources*. From the detailed description of operating practices, it will be possible to identify those key items which standards should address. Humble advocates a systematic investigation of any activity for which standards will be set in order to identify the factors which are essential to the success of the activity.[6] In order to be meaningful any standard should focus on a manageable, but significant, area of activity that can be delineated and measured. Once a specific area of concern (i.e., clinical records, treatment procedures) has been determined, it should be placed in its proper perspective to the overall program in which it exists. Standards should address only important or essential elements so that the whole standards process will not be an inefficient measuring of numerous minor activities.

PHILOSOPHIES

Prior to setting standards, the standards developers must analyze the expectations of agency leaders, legislators, clients and families, citizen support groups, professional societies, agency employees and third party payers regarding the philosophies that underlie the mental health service delivery program and the standards program itself.

The philosophies that underlie mental health programs are seldom made explicit. Any mental health program is based on a series of value assumptions which will obviously also underlie the standards by which the program is measured. Developing a *statement of philosophies* should be a primary step in setting the goals and objectives for any mental health program.

Such a statement of philosophies becomes as important for the standards program as for the overall mental health program itself. Philosophies determine in large measure which items are judged to be of sufficient importance to have standards applied to them. In addition, a great deal of the ultimate interpretation of whether a program is judged to be in compliance with a specific standard will depend on how well the activity conforms with the philosophy that underlies the standard. This is particularly true of those standards which call for flexible judgments. Without such a statement of philosophies, it is quite possible for two different observers to arrive at completely different judgments about whether an activity is in compliance based on their differing personal philosophies.

Examples of philosophical issues that are important to both mental health programmers and to standards developers are: whether the program is striving for social functioning of its clients or only for removal of psychopathology; the extent to which client dignity and freedom are important values compared to regimentation and standardization of meals, clothing and furnishings; whether the program is committed to or against any particular model of mental illness (i.e., medical, behavioral, social) or treatment procedures (i.e., psychoanalysis, electroconvulsive treatment, psychopharmacotherapy, group therapy, milieu therapy or therapeutic community).

There are also philosophical issues that underlie the setting and monitoring of standards. Decisions about the philosophies and purposes of standards will influence how often the standards are monitored, by whom, and the process by which it is done. The underlying philosophies will also suggest the means of data collection, the type of data to be collected and the uses to which the standards will be put. The most fundamental philosophical differences lie between the philosophy of standards as a means of control and the philosophy of standards as a means of facilitation.

In addition, philosophy may influence whether the standards are applied equally to public and private or voluntary programs. In the past, states have been loath to accept the same standards for public service and proprietary providers. Consequently, Burkett feels..."we have indirectly fostered, if not promoted, the development of a two-class system of care which requires of private systems with more limited resources, standards of service which the state, with powers of taxation, is unwilling to meet."[7]

Individual standards as well as the standards process have philosophies and purposes. In discussion of the uses of individual standards, Humble has pointed out that the identification of a specific standard's uses should determine the attributes to be emphasized in its design.[8] The design of a standard will vary depending on whether it is to be used to guide programs, to control costs or to monitor for detection and correction of deficiencies. Special care must be taken to avoid contradictions or ambiguity in standards that have multiple uses, but this can be helped by identifying all of the various uses to be made of a standard before it is drafted.

Two frequently mentioned purposes of standards are to assure quality of care and to contain costs. The two, however, are not compatible in many situations because "...in the provision of quality care and client safety it is seldom possible to adopt the most economical solution." Therefore, such standards must opt for maximum overall economy by striking a compromise between adequate quality on one hand and costs, effort and resources on the other. Sanders[9] emphasizes that in making a compromise, the economies of both the providers and the consumers must be considered. If the major purpose of the standard is cost containment, the standard will emphasize cost rather than continuous quality improvement. On the other hand, a standard which has quality assurance as its purpose will emphasize the inputs and processes without regard to costs. One of the dilemmas in overall standards results from this very conflict when there are two separate offices or agencies administering two sets of standards related to the same programs, but with one set focused on cost containment and the other focused on quality assurance. These must be coordinated lest the providers go out of business or the consumers not be able to afford the services.

The standards should also be related to the *goals and objectives* of the program. Goals and objectives of programs are not always as sharply written as they should be for best administrative use. In such cases the standards developer must often work to sharpen up the statement of program objectives before operational standards can be based upon them. Confusion occasionally arises between outcome and support goals. Outcome goals are the ultimate goals for patients or clients; support goals are goals for the program to work toward in doing its job. Both may be important for standards developers, for there may be standards related both to client outcomes and agency processes such as citizen inputs or maintenance of clinical records. Relatively greater emphasis needs to be given to outcome and performance standards.

Standards are not the same as goals and objectives, but they are derived from the objectives by providing an element of measurement. Standards must be measurable either in quantitative numerical terms or in terms of whether a specific attribute is present. Many of the standards will be related to the inputs and processes of programs rather than to the ultimate objectives. These items will be identified from the initial program description. However, the standards developer must take care that these input and process standards be as much related to program objectives as possible. This is particularly likely to be a problem in standards regarding staffing and procedures in which there is often considerable pressure from professional associations to have their professional members and procedures identified and protected by specific standards which may not be related to program objectives.

Another issue that must be considered at the start of the development of standards is what level or levels of programming are to be measured by the standards. Are they to address only the mandatory or critical levels of programming, or are they to focus on various intermediate program levels? Or are they to set forth ideal or optimal levels of programming? While most sets of standards have traditionally focused on only one level of programming, it is certainly possible to consider standards which might simultaneously address several levels. However, if this is done, the standards will require some special technique for identifying the different levels both in the standards document and in the monitoring process, so that both surveyors and the program providers will be clear about which levels of standards will be monitored for which uses.

PROPOSED PLAN OF DEVELOPMENT

When the preliminary planning work has been completed, the state agency will have sufficient information to produce a fairly detailed proposal for the development and use of standards in that agency. States which have set standards have found that the proposal should include a report and analysis of the information already gathered; a recommendation for the scope, type and uses of the standards to be developed; the steps through which the process will proceed; and recommendations regarding individuals, agencies and organizations that should participate in developing the standards. The proposal is then submitted to the state's mental health program director and his management team for their suggestions and approval. During this review the management team or the program director may suggest modifications or additions and add priorities for developing the standards.

Depending on the size and characteristics of the state's mental health system the plan may opt for some combination of, or one of, three basic patterns of development: 1) the committee approach, 2) the consultant approach, or 3) the "library" approach. One principle that is common to all three approaches is that they should operate on a consensus of opinion. According to Verman, a consensus is reached when the largest possible agreement is reached among representatives of all parties concerned with the use of standards—the stage agency, providers, clients and families, advocacy groups, professional groups and legal consultants.[10] Verman emphasizes the importance of consensus, particularly in cases where the majority of standards remain voluntary.[11] Even where compliance is required by law or regulation, consensus will make the implementation easier than an autocratic decision by a single person or a small group. The process of achieving a consensus may be time consuming and involved because of the participation of so many individuals and groups, but in the end will be worthwhile because of the improved communications and vested interest that all parties will have.

The *committee approach* and its associated variations uses committees, task forces or councils. The person responsible for developing the standards usually nominates individuals to the committees for each area of standards. These representatives should be persons who will be directly affected by the standards as well as program administrators and persons from advocacy groups. Since the committee members will be expected to reflect the views of their departments or programs, some prior consultation with their program chiefs and peers is desirable.

The *consultant approach* entails the preparation of a draft standards document by a consultant or by a group of consultants designated by the standards setting agency. A variant of this approach would involve hiring a consultant or consultants to work with the person or group which is charged with developing the standards in the agency.

The *"library" research approach* involves studying the standards already available from other groups (i.e., the Joint Commission on the Accreditation of Hospitals, other states, federal agencies) and adopting or modifying the most pertinent ones.

WRITING THE STANDARDS

The individual standard should be a concisely stated item which is to be used to measure a program or a facility element. The standard is then followed by any explanatory statements of definition, purpose, justification and interpretation.

The explanatory statement should be clear and concise and should include the reason the standard is important, the intention of the standard, including its expected effect on cost, quality of care, etc. It should also include any help that seems to be needed to interpret the standard and the data related to it during the monitoring process. The explanation is designed to guide the program in developing this service item and the surveyors who must measure it and make judgments about whether the program is in compliance. The interpretation will help prevent misunderstandings and ambiguities while giving the service providers a feeling of security that the actions they are taking are moving in the direction of complying with the standard. The explanatory statement might also cross-reference the state standards with each other and with those of various national and federal agencies that have standards in related areas.

While a glossary of terms is desirable for words or terms that are repeatedly used throughout the standards manual, terms which are used only within a single standard or section of the manual might be defined within the explanation for that standard. For example, a standard dealing with mental health workers might provide such a definition:

> *Standard*—the roles and functions of each level of mental health worker shall be delineated in a written statement that shall also include examples of work performed.
>
> *Explanation*—the term "mental health workers" is used to designate those individuals who, through experience, inservice training or formal education or all three, function in psychiatric facilities under a number of different job titles such as mental health worker, psychiatric technician, human service generalist, etc.[12]

If standards are to be used for program monitoring and evaluation, they should be written in a way that allows accurate and reliable measurement. This may involve the inclusion of levels of acceptable performance—a range of acceptable variation or specification of what is considered success in meeting the standard. The standards must be written so that they will allow the surveyor to make and record the appropriate measurements on whatever type of scoring or rating scales are to be used. Some standards will be measured by simply observing and recording the presence or absence of whatever attribute is required. Other standards will require a scale of compliance (i.e., from 1 through 5). The standard should make clear what measures are to be used.

The standard will also indicate whether it is part of a group of standards whose scores will be combined in some way to produce a composite picture of overall program performance and what specific weighting is to be given to this item. For example, fire and life safety standards are often weighted more heavily than standards having to do with aesthetics.

The standards should be written in simple but precise language which avoids technical jargon and legal terminology. Standards are received best when they are stated in the positive. For example, a standard dealing with medication would be better stated as "insure that 98 percent of all medications are administered properly," rather than "there shall be no more than two percent error in administering medications."

The tone of each standard will vary with the uses to which it will be put. The verb forms "shall" and "must" indicate mandatory standards; "should" indicates a commonly accepted or recommended standard; and "may" indicates an optimal or elective standard. In general these verb forms indicate the degree of latitude which will be acceptable for measuring. A mandatory standard offers little or no latitude in meeting the standard, while an optimal standard may allow considerable variation in measurement results. For greater usefulness of the standards, the wording and style of presentation should be consistent throughout the manual.

Standards should be written with a sensitivity to the needs of the client and to the problems of the service provider rather than in an arbitrary fashion that reflects primarily the authority of the regulatory agency. This will facilitate acceptance of the standards and will lessen complaints, or even law suits, from advocacy or provider groups.

For ease in implementation and adaptability to changing conditions, standards need to be flexible. This may be done by limiting the number of absolute or mandatory standards to a minimum while providing a range of acceptable levels or measures whenever possible. This will allow surveyors to make more flexible judgments based on varying geographic, economic or technological conditions.

While individual standards should remain flexible, the standards program itself should remain relatively stable. Standards should be revised frequently enough to adapt to changing technology or changing political and social expectations but not so frequently that the programs and services are kept in an unstable condition. Industry, for example, reviews and revises most of its standards every five years and all of them every ten years.

To make revisions easier, the standards might be issued in loose-leaf form to allow individual standards to be periodically revised or replaced or to allow new ones to be added.

Finally, to avoid a feeling on the part of programs that they are being inundated by standards, the state agency should avoid writing more standards than are necessary. It is recommended that only a minimal number of essential standards be generated during the state's initial development of standards. Later these can be refined and expanded where indicated, but even then every effort should be made to limit the number of standards to only those that are felt to be important to service delivery. There is often a temptation to write standards for items for which there is no evidence of a cause-and-effect relationship or for items that are principally matters of personal taste or opinion. Mohr estimates that 60 to 80 percent of all that is being done in manufacturing is *not* standardizable.[13] It seems reasonable that the mental health system, which can exercise even less control over its product and processes, may find a similar percentage of its activities are not standardizable.

THE STANDARDS MANUAL

The standards manual might well contain an introductory statement that reviews the goals, objectives and philosophies of the state mental health agency and the program area to be addressed by the standards in order to provide understanding of the background and context within which the standards will operate. This may help promote understanding of the mental health agency's mission and familiarize those using the standards with the directions in which each program is moving.

The introduction of the manual might also include an explanation of the state agency's authority to set and monitor standards, a discussion of any licensing or certification procedures and requirements which affect the standards, and a statement of the proposed uses to be made of the standards.

Following the introduction, the manual should contain a description of the framework within which the major standards components relate to each other and to the different program areas. This will indicate why each element of standards was chosen, how each element related to the other components (i.e., conflicts, mutual benefits), and the direction in which each element will move the program. For easy identification each standard and its major component area should be numbered or lettered in such a way that the standards can be readily differentiated along with their component groups.

The manual should also explain the monitoring procedures and the appeals process to be used. The monitoring procedures should be described in some detail including what type of review will be used (i.e., sampling or a complete review), what pre-survey questionnaires will be used, and whether peers or central office surveyors will conduct the monitoring. Schedules for all of this, along with procedures for developing plans of correction for items found out of compliance, should be clearly specified. The rewards or penalties to be used should be spelled out. The procedures governing exceptions, if these are allowed, and the procedures for appeals should be detailed clearly so that a service provider will understand the steps to take if he feels the need for either.

The manual also should provide identification of where to go for further information or interpretation of the standards and a roster of the persons involved in preparing the standards.

REVIEW AND COMMENT

After the draft of the standards has been prepared, it is ready for wide circulation to familiarize those who will be affected by them and to invite review, comments and criticism to use in modifying the proposed standards. Usually a time limit is set for the receipt of comments, and frequently public hearings are held. After the comments have been compiled, the proposed draft standards are rewritten and prepared for field testing. This includes having the proposed standards reviewed by legal counsel to assure that they comply with all pertinent state and federal laws. Following the reviews and field testing the proposed standards may receive a final revision before they are approved and adopted.

PROMULGATING THE STANDARDS

When the standards are to be used primarily as program directives or guidelines within the mental health agency, the process of promulgating them is relatively simple and informal, involving only a review of the draft standards by concerned groups and legal counsel and then adoption by the mental health agency's administrator. Standards which will be issued as regulations must follow the formal state procedures for issuing regulations and applying administrative law. These procedures usually include filing the proposed standards with some official body such as a legislative research commission or the Secretary of State and publishing them in the state's administrative register, after which they have the force of law.

Kentucky and Wisconsin offer examples of the process of writing and implementing formal standards. According to William Burkett, Director of the Division of Licensing and Standards of the Kentucky Department of Human Resources, Kentucky's mental health agency staff prepare the draft of the standards and circulate it for review by professional groups, providers and advocacy groups such as the mental health association. Legal counsel and a committee of consumers, providers, regulatory agency representatives, board representatives and special interest representatives also review the draft standards. Finally the proposed standards are reviewed, modified and approved by the Certificate of Need and Licensure Board.

They are then filed with the state's Legislative Research Commission which publishes them in the *Administrative Register* for 30 days. If anyone requests a hearing, the mental health agency holds one within 30 days and reports why the hearing inputs did or did not result in a revision of the proposed standards. The standards then become official in 30 days.

Dr. Kenneth Rusch, formerly with the Wisconsin Division of Mental Hygiene, explained that in Wisconsin the initial work is done by the Division of Mental Hygiene's program bureaus with informal input from the programs. An advisory committee composed of persons outside of the division reworks the material and circulates the draft among those who will be affected by the standards. After a hearing, the committee revises the draft and sends it to a review committee of the state legislature, where it must be approved for a public hearing. After that hearing, the draft may be rewritten or approved and published in the *Administrative Code*, after which it becomes official and assumes the force of law.

The implementation process in standards involves publishing them, notifying those who will be affected, providing technical assistance, coordinating continuing education programs for providers and surveyors, and setting up a process to study and evaluate the standards for future revision.

Providing technical assistance and continuing education to prepare program providers for monitoring and conducting training programs to prepare the standards surveyors are essential to the success of the standards process. At the very least, training programs should ease the process of implementing the standards by virtue of the fact that all key persons in the mental health system will be better informed.

One final step necessary to a standards program is to develop a set of procedures to evaluate the standards themselves and the monitoring procedures. Such a system will be useful for planning future revisions of standards, but a more immediate use for it will be to detect and correct problems, inequities and inappropriate procedures in the standards process as soon as they become evident. Such problems must be corrected immediately lest they continue to demoralize and weaken the whole standards program.

The procedure which is set up for the review and evaluation of standards for possible future revisions might rely on the experiences and judgments of a variety of persons who are involved in and affected by the standards: clients, advocacy groups, surveyors and the standards administrators.

FOOTNOTES FOR CHAPTER 4

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1. Southern Regional Education Board, *State Mental Health Standards: "How To Do It"* (Atlanta, Georgia: Southern Regional Education Board, 1976). P. 64.

2. *Ibid.*

3. Lal C. Verman, *Standardization: A New Discipline* (Hamden, Connecticut: The Shoe String Press, Inc., 1973). P. 145.

4. "Why Nobody Wants to Listen to OSHA," *Business Week,* June 14, 1976. P. 68.

5. Thomas N. Humble, *Standards in Strategic Planning and Control* (Austin, Texas: The University of Texas, Bureau of Business Research, 1966). P. 35.

6. *Ibid.* P. 41.

7. William T. Burkett, "Starting Out" in *Setting and Monitoring Standards in a State Mental Health Agency* Southern Regional Education Board (ed.). (Atlanta, Georgia: Southern Regional Education Board, 1976). P. 10.

8. Thomas N. Humble, *Standards in Strategic Planning and Control* (Austin, Texas: The University of Texas, Bureau of Business Research, 1966). Pp. 38-40.

9. T.R.B. Sanders, ed. *The Aims and Principles of Standardization* (Geneva, Switzerland: The International Organization for Standardization, 1972). P. 5.

10. Lal C. Verman, *Standardization: A New Discipline* (Hamden, Connecticut: The Shoe String Press, Inc, 1973). Pp. 11-12.

11. *Ibid.*

12. Joint Commission on Accreditation of Hospitals, "Mental Health Workers - Standard I" in *Accreditation Manual for Psychiatric Facilities: 1972* (Chicago, Illinois: Joint Commission on Accreditation of Hospitals, 1972). P. 79.

13. Lal C. Verman, *Standardization: A New Discipline* (Hamden, Connecticut: The Shoe String Press, Inc., 1973). P. 90.

CHAPTER 5

MONITORING STANDARDS

Monitoring is the process of gathering information about program operations or facilities to measure how actual performance compares with the standards and to develop plans for correcting when the programs are found to be out of compliance. Monitoring is an expected activity for most sets of standards—especially those that are used in some regulatory way. Monitoring provides the feedback loop which lets the agency know how the programs are doing compared to the standards, so that decisions can be made about licensure, certification, funding, etc., based on performance.

There are some instances in which there is no regular or required monitoring of standards—especially when the standards represent ideal or optimal levels of care and are used as guidelines for program or staff development. Even then there may be some limited monitoring by program administrators who use the monitoring data for program evaluation and future program management.

This chapter examines the monitoring process and discusses its purpose, internal and external uses, alternative methods and possible problems.

PURPOSES OF MONITORING

The major purpose for monitoring standards is to *provide data for internal management.* The routine monitoring process provides a regular source of information for various internal management uses. Among the specific uses the manager might make of the data obtained by regular monitoring of standards are:

To *identify deviations* from the program's planned course and to *institute plans of correction*

To *use as a basis for licensing programs* if licensure based on standards is a responsibility of the mental health agency

To *use as a basis for allocating funds* to programs. This may be done by awarding extra funding to help programs that are found to be below the level of compliance to come into compliance, or it may be done by awarding additional funding to those programs that are found to be in compliance.

To *scan for evidence of trends and potential problems* that may need attention. By attending to the data from routine monitoring of standards, the administrator may detect changing patterns of admissions, treatment, staffing, seclusion and restraint, expenditures, etc. The monitoring thus serves as an early warning system to detect potential problems and modify programs to meet changing needs.

To *evaluate programs* in order to decide whether to modify or expand them. The data from monitoring often provides the administrator with the bulk of the information he needs for program evaluation. This will also reveal unanticipated results. The monitoring process will often identify the reasons why programs are not achieving their objectives or are obtaining unexpected results. These deviations may result from powerful social, political or economic forces outside of the programs themselves.

To *compare program costs, results, etc.* between similar programs and between successive years, between different models of treatment, between different patterns of staffing, etc. These comparisons may be useful in achieving overall program efficiency.

To *identify issues requiring further training for staff.* Frequently the information obtained from monitoring standards identifies service delivery problems that can be solved by staff development programs.

To *provide information and technical assistance to the operating programs* regarding their program performance. Operating programs often become so engrossed in day-to-day activities that they don't take the time to review their own performance. The monitoring process by the state mental health agency provides the opportunity for the operating programs to take stock of their own operations. In addition, the standards surveyors may offer technical assistance at the time of the site visit regarding how certain programs might be improved. The operating programs have the advantage of a relatively objective review of their programs by the survey team. They may then use this data for future program direction, seeking additional funding, staff training, comparing their own program with similar programs or comparing their own program with its performance at earlier monitoring periods.

To *provide assurance to the public that programs are operating at the safety levels and treatment levels of the standards.* In order to provide this assurance, there must be some means of communicating to the various publics that the monitoring has been done and that the programs were found to be in compliance. This may be done through licenses or certificates that are publicly displayed, newspaper releases, and annual and special reports.

Occasionally an outside organization will want to do a special monitoring or audit of the agency's standards. This may be the legislature, a federal agency, a mental health association or a third party payer wishing to verify the accuracy, consistency and reliability of the program records and the standards monitoring process. These external audits check the monitoring procedures to verify that the standards are being firmly applied and followed. These audits report their findings and any recommendations for improvement. Such audits by outside organizations usually provide for greater public confidence and credibility in the agency's own monitoring procedures (unless glaring deficiencies are revealed). In addition, they provide valuable outside perspectives for the agency.

Throughout all of these purposes of monitoring standards is the notion of *accountability* which is the reporting back to administrators, legislators, clients, third party funders and the public that the funds are being used responsibly for the programs for which they were designated, and that the programs are attempting to achieve or maintain a specified level of care. The need to be accountable through periodic monitoring of programs need not be seen as solely restrictive. It can also be facilitative by raising the awareness and confidence of the various publics in the program so that they are willing to increase resources.

PREPARING FOR MONITORING

The decision will have already been made regarding whether the standards are to be regularly monitored, and individual standards will have been written with the monitoring process in mind. There will be specific measures for each standards item and an explanation for how this is to be measured and interpreted.

There will also be indications for whatever scoring or scaling is to be used.

If it has been decided that compliance with the standards will be mandatory, there will also be indications of the various categories of compliance (i.e., substantial, real or full compliance) which will be acceptable for the different components and program areas.

INFORMATION AND EDUCATION FOR PROVIDERS AND THE PUBLIC

For any standards program to succeed, it is necessary to conduct an awareness and information campaign to acquaint every potential user with the standards program, its philosophies, benefits, procedures, etc., as well as with the individual program standards and the measuring processes. A constant flow of information between the standards office and the program agencies will help keep the providers aware of developments in the field of mental health standards and promote an exchange of views about the standards themselves and about the monitoring process. Because of this concern, it is particularly desirable to reach the service providers, client advocacy groups, professional societies and third party funders with information about the details of the standards and monitoring process. This can be done through regular staff development programs, special workshops, hearings, presentations at regular staff meetings or organizational meetings, special articles in journals and newsletters.

The public also needs to know something about the standards process and the general monitoring procedures, but this information will be less technical than that provided for the persons more centrally involved. For these purposes the press, radio and television, public exhibits, and pamphlet handouts will probably be most appropriate.

TRAINING FOR SURVEYORS

A most important part of the preparation for the monitoring of standards is the training of the persons who will do the surveying. Each program to be monitored deserves the assurance that it will receive fair, knowledgeable and courteous consideration from the persons doing the survey. This training should include information about the kinds of programs they will be surveying, the specific standards and their measures and about the interpersonal aspects of being a surveyor. The latter poses some special burdens in that it often requires the individual to be rigorous in his inquiry and yet facilitative to the people in the program. Too often the standards surveyors have been cold and impersonal or even downright rude to cover up for their lack of knowledge of the programs they were monitoring or of the standards themselves. Such attitudes will make it difficult to implement the standards program and will quickly establish an adverse attitude that may result in complaints about the standards and appeals from the rulings. They may also provoke lawsuits.

ISSUES REGARDING MEASUREMENT OF PERFORMANCE

There are several issues regarding the actual measurement of program performance that must be decided before the surveying takes place. Most of the issues should have been considered during the development of the standards, but they should also be reviewed, and modified if necessary, before each monitoring cycle. Among them are:

> Will there be any *provision for variations* in the measurement process for programs with different forms of organization, resources, treatment methods, etc.? It often seems inappropriate to hold all programs to the same measures (i.e., a part-time satellite program and a comprehensive full-time program). This may be managed by having alternative measures for certain kinds of programs or by having only selected measures that apply to all programs while additional measures apply to better endowed programs.
>
> *Will weighting or composite scores be used?* Weighting is the process of giving greater emphasis to certain critical items (i.e., fire and life safety standards). The composite score is the summation of measures for several items within a component. It indicates the overall effectiveness in that component area although individual items may be deficient. It has the possible disadvantage, according to Humble, of allowing an outstanding performance on a few items to counterbalance unacceptable performances on other items. This must be guarded against although the composite score generally has a real advantage in providing greater flexibility and overall assessment of performance.[1]
>
> *What methods of measurement and degrees of variation will be acceptable?* *Measurability* is concerned with whether an item is scalable and what kind of a scale is used (i.e., normal, ordinal or interval scales). It is also concerned with the degree of allowable variation. For example, industry frequently allows a five percent variance. Mental health programs should probably allow at least this much variance on most items that require quantification.
>
> *Validity* is a key element in standards monitoring. Validity is the relevance of a standard or the extent to which it is a true measure of a given procedure or treatment. Omitting a pertinent element of successful performance or including trivial factors will skew the data and

destroy the validity of the standards.

Reliability of measurement is also an issue. Reliability is the degree to which different reviewers can be depended upon to give similar measurement results when measuring the same activity. Reliability depends on both the adequacy of the standard and the objectivity of the surveyor.

What steps are required to *improve the validity and reliability* of the measures? It will help if the standards and the measures are clear and precise. It may help to break down the specific elements to be examined. Field tests and experience will provide evidence of problem areas and possible solutions. Careful training and testing of the surveyors will help.

What *categories of compliance* will be acceptable and by what criteria will they be determined? The three commonly accepted categories of compliance are:

> *Substantial compliance*—the program has met the intent of the standards, complies with most of them and has an acceptable plan of correction to deal with deficiencies.
>
> *Real compliance*—the program complies with all of the standards, but not with every sub-item of each standard.
>
> *Full compliance*—the program complies with every point in the standards. Very rarely is full compliance required as it is almost impossible for the majority of programs to comply in full. Substantial compliance is much more realistic.

THE PROCESS OF MONITORING

There are many possible approaches to the monitoring process itself. Varying circumstances within the states will influence which one, or which combination of several, will be most effectively used by any particular state mental health agency.

In general there are four major areas of review that have proven to be most effective for monitoring. They are:

> *Review of program data*—This data is often supplied on self-reporting forms filled out by the provider program before the site visit. In some cases the program data reported on such forms is all that is reviewed. This is relatively inexpensive, but it has obvious problems of credibility.
>
> *Review of clinical records*—This usually requires a site visit and is most appropriate for review of professional care and treatment. It is the approach being used by Professional Standards Review Organizations.
>
> *Review of programs*—This also requires a site visit with observation and measurement of the program. This has an inherent problem in mental health programming since much of what goes on in a program is not easily observed and measured.
>
> *Review of premises*—This is particularly applicable to facility standards where the buildings are observed and measured.

Most states that have monitoring of standards use some combination of these approaches.

METHODS OF MONITORING

There are several alternative methods of monitoring standards. The agency's choice of method will depend on resources available, the personal philosophy of the agency administrator, legislative and political sentiment and possibly court decisions. Various combinations are possible:

> *Self-reporting*—Self-reporting relies on each program to accurately and truthfully report its achievements on forms supplied by the state mental health agency. The agency which opts for this method may decide to accept the data as supplied by the programs, or it may carry out spot-check visits to assure the veracity of the data. As a

variation, the agency might decide to site-visit only those elements which the programs had previously reported as out of compliance (management by exception) or only certain elements which the agency had tagged for verification.

The self-reporting method requires the smallest staff and thus is the most economical. It provides the data in a business-like way without overtones of inspection or punishment and promotes self-evaluation as the program staff work to complete the forms. The major drawback in self-reporting is that programs not in compliance are tempted to "fudge" the reports a bit to make their programs look better, and the deficiency then will slip by undetected. Occasional spot checks can reduce such incidents. Another disadvantage is that the reliability is often poor because some program people will be overly conscientious in their responses while others will tend to be somewhat cavalier and imprecise.

Inspector general—The inspector general method uses a single individual who makes the site visit to survey the standards. This person is usually well trained in the surveying process, but seldom has great expertise in all of the program areas for which the standards apply. This method has the advantages of being relatively inexpensive because it employs only one person, and the level of reliability is high because only one person is involved. However, in addition to the disadvantages of the inspector having little depth of program expertise, it often requires delays in making all of the surveys and follow-up visits because of the limited time of a single person. It also has a tendency to raise adverse feelings in the program people who may accuse the surveyor of being rigid, arbitrary or even biased against them.

Interdisciplinary survey team—The interdisciplinary survey team method uses a team of professional and lay persons from the central office. These persons represent the various clinical and administrative professions and are knowledgeable about the particular program areas they are reviewing. In some cases the teams also include representatives from advocacy groups or legislators who may participate as observers or as active reviewers, especially when they have had training to prepare them to function as surveyors. There is usually a representative from the standards office on the team to give assistance to the measurement and procedural aspects.

The mix of a variety of professions and personalities provides for many perspectives. The provider programs are likely to feel that they have been better understood. The lay members provide assurance of the citizen interest in quality programming, and the whole process is likely to be regarded as colleagual and fair. It also provides for considerable input of technical assistance during the survey visit.

The major disadvantage is the costs of having such a team of professionals assigned to surveying standards, and the difficulties of scheduling all members of such a team to visit all of the programs that need to be surveyed. The team members are sometimes accused of being partial to their own professions or to programs which are similar to those in which they have worked.

In some agencies these interprofessional teams are put together from operating programs on an *ad hoc* basis for specific site visits. This offers additional problems of training these persons and maintaining confidentiality. There also may be questions of whether their time would have been better spent working in their own programs. However, in this process a great deal of staff development and technical assitance takes place that may benefit both the surveyors and the program being surveyed. These benefits are in addition to the immediate benefits of the standards monitoring.

Peer review—The peer review method uses a team of professionals who formally assess the quality and efficiency of services performed by other practitioners in the same profession or in the same kind of program. The peer reviewers might be drawn from within the mental health agency or from programs external to it. The Professional Standards Review Organizations generally recruit community practitioners for their peer review of clinical activities.

The peer review system is often a two-level system in which the peer review team makes a judgment centered around the quality of care. The state standards program then reviews the team's decision in light of other procedural issues and costs. Gustafson has reported that "there appears to be opportunity for the agency staff to influence the process of...evaluation by shaping the agency, channeling the flow of information to and from outside advisors or actually altering or overriding their decisions."[2]

Peer review has the advantage of being performed by professionals who have experience in the area which they are surveying. This costs the state less than hiring full-time professionals to staff a monitoring program in the agency. Peer review tends to be more colleagual and educational and less adverse than other methods. Many states feel that the educational experience is a two-way street in which both the surveyor and the program being surveyed benefit. The credibility of peer review depends on the integrity of the professionals involved. Peer review is sometimes criticized for allowing cronies to promote pet projects, or for permitting backscratching or for illicit cooperation or even revenge. Such charges have implications for more than just the peer review process; the entire integrity of the profession is called into question. Aware of these criticisms, most peer reviewers lean over backwards to avoid any appearance of partiality and many times end up judging a program more stringently than would other surveyors. Peer review is sometimes criticized for taking the professionals away from their clinical or administrative responsibilities of their own programs.

Critics have recommended three improvements in peer review:

Peers should be chosen by random choice or according to specific criteria (i.e., areas of specialized competence such as chronic mental illness or child psychiatry).

Decisions should be based on formal standards and associated measurements rather than on personal considerations or unspecified professional ethics.

The identities of reviewers should be protected by editing comments which might identify specific individuals.

The Professional Standards Review Organizations[3] are a good current example of peer review which monitors all clinical activity according to criteria set by peer practitioners. The PSRO must assure that the services are medically necessary, meet professionally recognized standards and are provided as economically as possible. The PSRO program, according to Hoek, is a "health professional-controlled but publicly accountable approach to health care review. Its basic assumption is that health professionals are the most appropriate individuals to evaluate the quality of medical services and that effective peer review at the local level is the soundest method for assuring the appropriate use of health care resources and facilities."[4] Peer review programs in mental health should include a wider range of professionals and paraprofessional workers in addition to psychiatrists in order to provide for review of all professional activities.

Sampling method—The sampling method uses technical experts from the state agency to survey programs on an episodic or regularly scheduled basis to check on certain components of the program's records and procedures. The sampling or audit is designed essentially to verify the financial and clinical records and reporting methods of a program rather than to measure the programs themselves. The sampling method is less costly than full surveys because it requires fewer persons. Fewer persons visit the program although a survey visitor may sometimes stay longer and become more intimate with the program's operation so that he may make recommendations for improvement. This method also requires fewer hours of preparation and surveying time on the part of the service program staff.

COMMON STEPS IN MONITORING

Regardless of the method of monitoring standards, there is a series of more or less common steps that will be taken in the overall process.

In preparation for surveying, the state agency develops an annual schedule, composes and trains its survey team, and sets the tentative agenda for each visit. The schedule must take into consideration the work loads of both the standards surveyors and the programs to be surveyed, as well as any other crucial dates such as those set by federal offices, expiration dates of contracts or grants, renewal dates for licenses, etc.

In most cases once the specific dates for the survey visits are set, the programs are notified and asked to complete a set of self-survey forms or to supply certain reports and information about the program. These forms and other information materials are included along with copies of previous survey reports in a surveyor's packet which is given to the team members to review in preparation for the visit and to use at the time of the visit. As the date of the visit nears, a tentative agenda is prepared, to be finalized at the time of the visit.

During the survey visit, the initial activity of the survey team is to meet with key staff and board members of the program. At this time the team leader reviews the survey procedures and purposes, and the program staff offers any overview of the program's operation and problems. The agenda is reviewed and finalized, and specific team assignments and appointments are set. Frequently team members are assigned some overlapping responsibilities in order to cross-validate the survey results.

The surveying itself may be carried out by observations of staff activities and procedures and the facility itself; examination of program records; interviews with unit heads, program staff, board members, clients, community persons; and verification and elaboration of the information on the self-survey form.

Before leaving the program, the team members individually rate the services and facilities to which they were assigned and exchange the data with the other team members. This interchange of data, especially in the overlapping areas, serves as a check of the validity and reliability of the overall survey.

The team then provides an exit conference with the program's key staff and perhaps board members, at which time the team presents its findings, including the program's strengths and weaknesses. Items that are out of compliance are identified and discussed with particular attention to a plan of correction. The review team also makes any overall recommendations it may have, and encourages the program's staff to ask questions and offer rebuttal if they wish. All of this is recorded.

After the survey visit, a written report of the survey results is prepared and sent to the program. The program is requested to prepare a plan of correction to remedy any deficiencies, and this is later approved. Then a follow-up visit is scheduled at some appropriate time to review the corrections. It is important that the written report be fed back promptly, usually within 30 days. This repeats the strengths, weaknesses, deficiencies and recommendations that were offered by the survey team at the exit conference, but it offers confirmation which the program may use with its other staff members, board and other support groups.

The program is also requested to submit a written plan of correction for any deficiencies and is given a specific time period within which to submit the plan and to make any corrections. Life endangering deficiencies must usually be corrected immediately, while other deficiencies may be scheduled over a period of time. Costly items are especially likely to require a longer time for correction. If the program is not able to develop an acceptable plan of correction by itself, the state agency usually will offer technical assistance. A follow-up visit is scheduled within a specified time period after the corrections are supposed to have been made.

In cases in which a program is dissatisfied with the survey findings or the procedures, there is usually a mechanism for an appeal hearing. This appeal must be requested within a specified time after the program has received the formal written report. The program may appeal the findings of the survey, the conduct of the team members or even the validity of the standards. Not all states permit appeals on the basis of validity of the standards because such appeals might be used as disruptive, delaying tactics by individual programs that are not in compliance. The agency may appoint an officer to investigate the case, or it may schedule a formal hearing. Usually these procedures are sufficient to resolve any disagreements. However, if a program is still in disagreement with the decisions after exhausting all administrative steps, it generally has the right to go to court—particularly if the decision results in some significant cost or penalty to the program.

The sanctions that the mental health agency might employ to encourage a program to come into compliance vary from none at all to the revocation of the program's license to operate. They may include persuasion and technical assistance; issuing a grading certificate which will allow the program to offer only limited services; the awarding or withholding of any discretionary state funds; recommending to federal or third party agencies that certain funds not be paid or awarded to the program; and finally revocation of the license.

EVALUATING THE STANDARDS PROCESS

The validity, reliability and efficiency of the standards process will be improved if the entire standards operation is under continual evaluation. Evaluation will weed out poorly written or inappropriate standards, and it will identify weak spots or problems in the monitoring process which can be modified or corrected.

Some of the techniques for evaluating the standards are:

Recording and periodic analysis of all complaints, appeals and refusals to comply. These may reveal real problem areas.

Recording and analysis of all problems presented by monitors, consultants or service programs related to the standards.

Periodic analysis of the standards themselves to determine which ones frequently seem to be troublesome, vague or meaningless. The same might apply to the monitoring procedures.

Problem areas that may be identified and corrected by evaluation are:

Standards or procedures that do not produce usable data for management purposes

Standards that are unmeasurable or irrelevant

Survey schedules or procedures that excessively disrupt programs

Inadequate communication of survey results.

Close evaluation of the measures found on specific standards will provide hard data on which to refine and sharpen the standards. At present there is some criticism that standards are too often based on consensus judgments with an insufficient data base. Evaluative research of the data obtained on standards will provide a quantitative basis for the standards and also advance the science of the delivery of mental health services.

PROBLEMS AND CONFLICTS

As the number and complexity of standards has increased, the conflicts and confusion have grown more numerous and more serious. Many of these could be resolved or lessened if the persons who administer standards were more aware of them and more sensitive to the problems the conflicts are causing.

Among the specific problems are:

Overlaps and conflicts between the standards of various agencies and organizations—With all of the various federal, national and state agencies and organizations that set and monitor standards, there are bound to be some overlaps and conflicts. Standards of the various agencies often apply to the same program components (i.e., facilities, records, support services), but the criteria are often different or the procedures and interpretations are different. Sometimes the criteria are actually at variance with each other, but more often the difficulties are in the procedures and interpretation rather than in the standards themselves. The programs are then put in the position of deciding which set of standards to follow. The state agency can provide assistance by establishing rules for which standards shall apply in the case of conflicts. Florida already does this.

Often the self-survey forms of the various standards agencies ask for virtually the same data, but in slightly different forms (e.g., birthdates rather than ages) or for slightly different time periods (e.g., September 1 rather than July 1). These could be made more uniform and still provide the same useful information.

Frequent changes in the standards or in the monitoring procedures can be very disruptive to programs that are trying to stay in compliance. There is need for a considerable measure of stability in standards programs as well as for periodic review and revision. Some program areas have had especially serious problems with changing criteria. Drug abuse programs in one state found that the criteria for program funding had changed from drug-free care, to therapeutic community, to methodone maintenence, to emergency care, to education and prevention—all in a four-year period. This is an example of rapidly changing regulations, but the related standards also were rapidly changing.

Closely related is the problem of *continually upgrading the requirements of the standards* so that the programs must play an everlasting game of catch-up which they can never win. This poses special problems where there are no concomitant increases in funding or fees to cover the increasing costs of upgrading the programs. This kind of problem results when professional and advocacy groups are able to exert considerable influence on the quality standards, but have no regard for the expense or funding. The state agency is in a position to negotiate a balance between quality and funding in the standards that apply to the programs over which it has surveillance.

The conflict between *quality and cost* in standards is always present, even when the standards remain stable. This is aggravated by the tendency in medical care to think only of the highest quality of care as being adequate, with almost no regard for the expense. The state agency must very carefully examine its standards to assure that they do indeed represent essential quality items rather than just protection for certain professions or traditional values and practices. This involves the consideration of different levels and models of care and carefully re-examining the basic philosophies and objectives of the programs.

Some of this conflict can be resolved by field testing proposed standards and then modifying those that are found to be too costly. However, the same process may be applied after the standards are implemented by recording and analyzing the costs of complying with the various standards, and then making appropriate changes at the time of major standards revisions.

Of course, the state may elect to provide additional funding to enable the programs to meet the higher quality standards or provide technical assistance to help programs become more efficient in meeting the standards with the available funds.

The cost of preparing for survey visits and hosting the survey teams is also a problem. Some programs estimate that it requires as much as 247 man-days a year to fill out survey forms, host survey teams and prepare plans of correction for various sets of standards. This is the equivalent of one full-time professional person. It is expensive and often non-productive, particularly when so much of it is repetition or duplication of what has already been done for other standards agencies.

The costs might be alleviated by the state agency taking the initiative in recommending core standards, common presurvey data and combined monitoring. It should be possible in most cases for several standards groups to accept the monitoring findings of another group, rather than each doing its own monitoring using its own standards, forms and procedures. The Joint Commission on the Accreditation of Hospitals is now working on core standards for all of the standards programs administered by its Psychiatric Facilities Council and is exploring the possibility of core standards for all of its programs. This is a step in the right direction. The states would do well to support this effort and to encourage its use with other standards groups.

Core standards would greatly simplify the whole standards operation. Common items would be surveyed one time for all program areas, and only those program elements which require unique standards items would have their own standards and survey procedures. Thus there might be core standards for facilities, clinical records, privacy and confidentiality, staff development and support services such as pharmacy and dietary services, but specific standards for the clinical services of drug abuse, emotionally disturbed children or geriatric psychiatry.

Another problem results when *standards are used for purposes other than those for which they were intended.* There are many examples of a set of standards developed for a specific use being applied to other purposes. The most prominent current example is the standards of the Joint Commission on the Accreditation of Hospitals, which were developed for voluntary accreditation, but which are now being used as the basis for funding decisions by federal payment agencies. This example is further complicated by the fact that the federal agencies are requiring not only that the standards of the JCAH be applied, but that the programs be accredited by JCAH to be eligible for the funds. Thus, standards which were designed for use as a carrot are being used as a stick. This dilemma can be avoided by clearly thinking through the uses that will be made of the standards and then either modifying the standards and procedures or making provision in the standards for the flexibility and variations that different uses require.

Another possible conflict results when the *same professionals who set the standards survey them.* It is preferable to separate these two functions in order to increase objectivity. In general, program people should decide which standards are important and what the standards should be, but surveying should be carried out by a separate office or team using the standards developed by the program people, applying more objectivity to the review than might be used by program people serving as surveyors. This procedure will help identify vague or ambiguous standards or criteria as well as provide greater objectivity.

Obviously many of these conflicts may be avoided by clear thinking and careful planning in the developmental stages of the standards process, but they can still be detected and resolved when the standards are evaluated and revised.

FOOTNOTES FOR CHAPTER 5

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1. Thomas N. Humble, *Standards in Strategic Planning and Control* (Austin, Texas: The University of Texas, Bureau of Business Research, 1966). P. 47.

2. Thane Gustafson, "The Controversy over Peer Review," *Science*, 190 (4219) December 12, 1975. P. 1064.

3. Harry C. Schnibbe and Anne B. Drissel-Duncan, eds. *PSRO and the Alcoholism, Drug Abuse and Mental Illness Services System* (Washington, D.C.: National Association of State Mental Health Program Directors, April, 1976). P. 4-6.

4. *Ibid.* P. 6

CHAPTER 6

ORGANIZING AND STAFFING

This chapter explores standards patterns, alternative locations for standards programs within a state's mental health or human service agency, possible staffing and possible relationships with other programs of the agency and with other state and national agencies.

The location and organization of a standards program within a state mental health agency will depend on a number of factors: the philosophy of the agency administrator and his management team; the uses which are to be made of the standards program; the overall policy of state government (i.e., the legislature, the governor, the director of budget and administration); special demands that are being made by courts, advocacy groups, etc.; and the resources available both in funds and in personnel.

PATTERNS OF STAFFING AND ORGANIZATION

Within a state mental health agency there are many possible patterns for organizing and staffing a standards program. The divergent circumstances in several states preclude the recommendation of any one pattern over another.

A very basic issue is the matter of centralization versus decentralization of the standards program. The extremes are a strongly centralized office responsible for all standards and licensing activities within the state's umbrella department of human resources on one hand and no state standards office at all on the other. Under the second pattern, the state mental health agency would simply encourage the various service programs to take whatever steps are necessary to comply with the standards of outside agencies and organizations. The monitoring of much of the standards data could be done through the management information system with perhaps an *ad hoc* committee to review the data for compliance and to make recommendations for actions to be taken on it. While such an arrangement is possible, there are some definite disadvantages in the lack of visibility and overall coordination. In general it is recommended that there be at least one person to assume the responsibility for the standards program—even if this person does not have a separately designated standards office or unit.

There are many possible variations between these extremes. They include:

A central standards program within the mental health agency itself

A standards program for each of the major program areas (i.e., alcohol programs, community mental health programs, mental hospitals, drug abuse programs, mental retardation programs)

A standards program delegated to regional offices

A standards program that depends on self-monitoring by the service programs with an occasional sampling visit.

CENTRALIZED PATTERNS

The advantages inherent in the more centralized patterns include economy of scale; greater consistency of the standards and procedures; better coordination of monitoring, data gathering and interpretation; increased visibility and credibility; better focusing of activities related to programming and compliance; central storage of documentation; increased ability to resolve disputes about standards; a stronger source for technical assistance; a more comprehensive standards operation. However, the centralized pattern has the disadvantages of a more authoritarian image, greater organizational distance between the monitors and the programs, an occasional insensitivity to local needs and a tendency toward prescription.

DECENTRALIZED PATTERNS

In general decentralized patterns offer the advantages of broad participation in the standards program, opportunity to aid internal management and to improve local level administration. They have the disadvantages of little regularity in measuring and interpreting standards, of often having a low priority, of using persons with relatively less expertise in standards work, and of using personnel whose time might otherwise be devoted to local clinical or administrative responsibility.

Both centralized and decentralized patterns offer the option of employing only a single person or a staff of personnel to develop and monitor the standards. While it appears to be more economical to have a single person, it appears to be nearly impossible to find someone with expertise in all areas of the standards process. Using a staff of persons allows each person to specialize in one or more areas and allows a more collegual, less authoritarian atmosphere.

It is recommended that in either case, the functions of developing standards be separated from those of monitoring the standards. Separating the standards development from the monitoring lends credibility and accountability to the standards program, and removes the likelihood that the monitors will give good scores to prove that their standards were appropriate and well written.

The preferred pattern is to have local program people develop the standards with some technical assistance from the standards experts, and then have a smaller group of persons from the standards office monitor them. These persons can then be more carefully trained for the task of monitoring and can be more uniformly objective about their findings.

LOCATION AND ORGANIZATION

There are significant issues in how the standards setting and monitoring function of a state mental health agency is organized and how it relates to the rest of the agency, to other agencies of state government and to the field operations to which the standards are applied.

The organizational form will depend to a large degree on the scope of the program. If the standards operation is to be extensive, it will need relatively independent status. If its purpose is to be primarily an aid to program development and staff development, it might be organized in relation to clinical program services. If its purpose is to be primarily cost control, it might be organized within the administrative services. If its purpose is overall compliance with various national standards and regulations that include standards, then the operation might be linked to program evaluation or whatever office manages other quality assurance programs. It is usually the responsibility of higher management to evaluate the findings of the surveyors to decide what actions should be taken, but certain evaluative actions regarding compliance matters may be delegated to the standards office.

In general, if the standards program is to have significant impact, it seems desirable to have a separate office for standards rather than expecting that standards activities will be something added on to the duties of another office on a part-time basis. This is particularly so if the agency plans to develop and monitor its own standards rather than simply helping its local operating units come into compliance with the standards of outside groups. Such an office of standards might be lodged within one of the major operating divisions of the agency such as clinical services or administrative services—or it might be set up as a separate staff office reporting directly to the agency director, much the same as legal services or public information services often are. The office will be variously perceived according to where it is lodged and probably will function with varying priorities depending on its organizational location.

In a few states in which there is an umbrella agency such as a Department of Human Resources, all of the standards and licensing activities of the entire agency are organized into an Office of Standards and Licensing. This has some definite advantages:

1. All of the standards and licensing procedures for all of the state's human service programs can be coordinated and simplified. This avoids the all-too-common problem of local hospitals, mental health centers, day care programs, etc., having to be surveyed and approved by several agencies. One survey does it all.
2. The office has higher visibility with the public, the media, the legislature, etc. This tends to increase credibility, but it also may attract more complaints and law suits.
3. The office can refine its policies and procedures to a higher level and operate more efficiently than several separate standards offices in each of the agencies.

For most states, the standards for mental health are developed and monitored within the mental health agency. This poses many organizational options—from having a strongly centralized standards office for all program areas (i.e., mental hospitals, alcohol and drug abuse programs, mental health centers) to allowing each program area or even each geographic region to have its own standards program. In most states there will be some kind of centralization so that the standards are consistent and procedures cause the least inconveniencing of the operating programs. This might be just a clearinghouse through which the proposed standards would pass and which would coordinate the monitoring visits. Conflicting standards and duplicated survey visits could thus be weeded out. This may be paired with a system that has standards surveys at the local levels reporting their data to the central clearinghouse where it is evaluated and passed on to management or to other outside organizations which require the data. This arrangement might allow for more continuous monitoring and reduce some of the tension about survey visits.

FUNCTIONAL RELATIONSHIPS

Regardless of where the standards program is located, it will want to establish certain functional relationships to other parts of the agency.

1. *Program services*—in the initial development of the standards and in periodic revisions, the standards office will require inputs and review from the persons responsible for the appropriate program areas (mental hospitals, mental health centers, alcohol or drug programs). In many agencies, the program services develop the standards. This not only assures that the standards are operational and relevant to the program services, but also makes it more likely that the program services will support the standards and encourage compliance.

   Program services will also be kept informed at all steps of the monitoring process, especially of the findings and recommendations for any corrections required in order to achieve compliance.

A question arises whether to consolidate the standards setting and monitoring for each of the program areas for which the state mental health agency has responsibility. It is recommended that these different standards programs be consolidated into a single standards office whenever possible. This provides the greatest opportunity for uniform standards, procedures, interpretations, etc., and for the greatest efficiency of surveying and managing the whole standards process. This consolidation will be especially appreciated by service programs that have two or more of the program areas within their operation.

2. *Program evaluation*—The findings of the standards office will be made available to the program evaluation section since the standards monitoring is essentially a program evaluation process to assess how well the programs are functioning in respect to the standards that are expected to guide them.

3. *Staff development*—The staff development office will be related to the standards office in two ways:

    a) Helping the staff of the programs to understand the standards procedures, the meaning of compliance, plans of correction, etc.

    b) Helping the staff come into compliance on procedural matters which the standards monitoring process reveals to be out of compliance (e.g., helping the staff understand treatment procedures or patient protection procedures on which surveyors find they are deficient).

4. *Administrative services*—The relationship of the standards office to administrative services will vary depending on the kinds of standards and the major uses of them. If the standards are facility standards or administrative standards or if they are being used primarily for cost control, there will surely need to be a close functional relationship to administrative services. Virtually all standards, except clinical treatment standards (PSRO), require some attention to the administrative structure and procedures of the program so that there is almost sure to be some relationship to administrative services within the state agency, especially in the development and in revisions of the standards that will apply to the

facilities and administrative services. The results of monitoring of these aspects of the standards will also be reported back to administrative services.

5. *Field operations*—The field operations (i.e, mental hospitals, mental health centers, drug and alcohol clinics) are the agencies to whom the standards are applied. The office that has responsibility for standards should be administratively separate from the field operations for the administration and monitoring processes. Ideally, the field operations personnel will be involved in the initial development of the standards and in any revisions. They are the ideal persons to describe what standards they believe to be most appropriate and significant, and they are also better able to state the standards in the kind of operational terms that are most useful for line operations.

   The field operations will, of course, be regularly involved in communications about survey visits, items found out of compliance, plans for correction, etc. The field operations should also be involved in the evaluation of standards and in any review and revision processes.

6. *Other standards-setting groups*—The standards office will provide a major liaison role with other groups that set and administer standards such as the Joint Commission on the Accreditation of Hospitals, the various federal agencies and other state licensing or certifying agencies. Their role will be to coordinate and simplify the standards procedures and schedules of all of these various groups. In some cases there may be actual conflicts in the standards of these various groups, but the greater likelihood is that there will be conflicting schedules, monitoring procedures, interpretations, etc. An aggressive standards office can help simplify some of these conflicts that often seem to be harrassments to the agencies to whom all of these conflicting standards and procedures are applied.

STAFFING

There are no firm rules for staffing of a standards program. There is no profession uniquely qualified to do standards development and administration. The work is primarily administrative rather than clinical, and so the director of the standards office or program should be a capable administrator. However, it is also well to have this person be a capable clinician or program administrator who has a broad understanding and experience with the program areas to which the standards will apply. Most of the persons presently in standards development and administration are experienced clinicians. Of course the persons who do the actual survey visits and who make the ultimate judgments about the degree to which the programs or facilities are in compliance with the standards must be persons who are knowledgeable about the program or facility areas about which they are making the judgments.

PERSONALITIES OF STANDARDS PROGRAM STAFF

Perhaps more important than the professional training or experience of the persons who staff the standards program are their attitudes and personalities. Persons are needed who are value oriented toward developing and administering standards so that the programs will be facilitated in coming into compliance to assure an adequate level of care for the patients. The role is that of a facilitating administrator rather than that of control. Yet personnel must be able to make decisions and take firm actions that may be unpopular although appropriate. They should be persons who can effectively administer authority, but should not be compulsive or authoritarian. Otherwise the standards program is likely to arouse resentment and resistance from the field.

These persons should not be "therapeutic" in the clinical sense, but they must be oriented to the uses of education, consultation, encouragement and facilitation. They should be adept in the uses of recognition and reward rather than the use of control, denial, punishment, literalism and rigidity. They must be good listeners with tact and empathy, yet they must be clear thinkers who understand the technicalities of federal and state regulations and the complexities of administrative law.

They must have the ability to organize their work, meet deadlines and work comfortably with management. They must also be systems oriented to envision the whole gamut of purposes, philosophies, procedures, etc., and be sufficiently analytic to discriminate the more subtle issues in regard to standards development and use. Many of these issues are still unclear in the minds of many writers and administrators, so the person chosen to be a standards administrator must have sufficient skepticism to effectively question all that is written or spoken to determine just what is the most appropriate course to follow in each particular situation.

The numbers of staff persons needed in the standards office will vary with the scope of the state agency's responsibilities (that is, whether it has mental retardation, alcohol and drug abuse, as well as mental health responsibilities) and the extent of standards usage within the agency. Staffing will also depend on what method is used for monitoring. If the cadre of survey visitors is full-time in this work, the standards program will be somewhat larger than if the surveyors are recruited temporarily from peer programs or if self-evaluation is the method chosen.

GLOSSARY OF TERMS

Administration - The conducting or directing of a program. It includes participation in deciding the objectives and obtaining the resources as well as carrying out a program once it is set in place. Syn: management.

Advocacy Groups - Organizations which lobby and work on behalf of specific programs. In the case of mental health programs, the advocacy groups are such organizations as the mental health associations and the associations for retarded citizens.

Compliance - The act of coming into accordance with a standard or regulation.

Continuing education - Training activities to update or deepen competencies for staff persons who have previously completed their basic professional education. Such training may be provided by educational institutions or by operating agencies.

Management - The conducting or directing of a program. In this document "management" is used synonomously with "administration."

Monitor - To provide surveillance for operating compliance.

Norm - A designated measure of average performance. There are several methods for calculating the average.

Professional Standards Review Organizations - Local organizations of professional persons, usually physicians, established by federal law to develop and monitor the clinical practice offered to hospitalized patients.

Program - A mental health service entity operated directly by the state mental health agency or by a local board which has some responsibility to the state agency.

Program evaluation - Systematic efforts to determine the effectiveness, efficiency or side effects of a program.

Regulations - Formally developed and officially promulgated directives for the conduct of clinical or administrative activities to which they apply. Regulations are generally issued in some kind of official register (e.g., the *Federal Register*) and assume the force of law.

Reliability - The quality of being dependably reported in the same way by all observers and at all times.

Staff development - Activities to improve the competence and efficiency of the manpower of a program or agency. It includes training activities and other activities to improve functional efficiency.

Standard - A statement describing the level of specification or performance against which one can measure physical plant, individual effort, functional activities or organizational achievement.

Input standards - Standards which spell out the required resources which are presumed to assure a certain quality of program. These may be set in terms of staffing, equipment or facilities.

Process standards - Standards which specify clinical or administrative procedures which are presumed to assure a certain quality of program.

Outcome standards - Standards which specify the results and levels of accomplishment for clinical and administrative effectiveness of a program.

Survey - To formally inspect or examine in order to gather information to ascertain the level of performance on standard items.

Technical assistance - Provision of specialized expertise to persons in operating positions. This expertise may be provided through a variety of mechanisms (e.g., consultation, workshops, special training, etc.).

Validity - The quality of soundly representing what an item claims to be representing.

APPENDIX A

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APPENDIX B

SURVEY OF STANDARDS DEVELOPMENT AND USE IN STATE MENTAL HEALTH AGENCIES OF THE SOUTH

INTRODUCTION

In early 1976, the Mental Health Program of the Southern Regional Education Board (SREB) did a survey of the development and use of standards in the mental health agencies of the 14 Southern states.* This survey was one activity of a project to develop better guidelines for the use of state level standards by state mental health agencies conducted under contract with the Office of Program Planning and Evaluation of the National Institute of Mental Health (Contract No. ADM-42-74-90(OP)). The survey was designed to gather information about each state's present stage of the development and use of state standards, the types of standards in use and the values and philosophical assumptions associated with those standards. It also asked for information about the staff and budgets committed to the development and monitoring of standards and any recommendations for problems that were being encountered.

Because the responsibilities for various aspects of mental health programs are split among several different agencies in some states, the survey received information from a total of 19 different agencies in the 14 states. Responses contain data on the mental health programs of all states(14), the mental retardation programs of 11 states, and drug abuse programs of 9 states, and the alcohol abuse programs of 8 states. A survey form was used for nine of the states. The remainder were reached by telephone or in person. Whenever possible, even those states that responded on the survey form were called by telephone to obtain further explanation of specific items.

This report examines the responses of the 14-state region as a whole and does not attempt to summarize individual states or to draw any conclusions about a specific state. The description and analysis that follow provide an information baseline about existing state level standards activities. It will also aid in the production of alternative suggestions for how a state level mental health standards program or office might be staffed and organized and how the standards process may be used most effectively for management purposes.

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*Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia and West Virginia

STAGE OF DEVELOPMENT

The state mental health agencies were asked to indicate the present stage of development of their standards programs. All 14 states are in some stage of standards development. (Table 1).

1. *Mental hospital standards*—For mental hospitals, four have their own standards in operation and five more are operating with the standards of the Joint Commission on the Accreditation of Hospitals (JCAH). One of these five is presently developing its own standards in addition to those of JCAH. Five more states are in the early stages of developing state standards.

2. *Community mental health centers*—With respect to the community mental health centers, eight now have their own standards in operation, and an additional three will use or are considering the use of the JCAH standards that are now being developed for community mental health centers. In almost every state in which standards are in operation, there is also monitoring. Three states are still in the early stages of planning and development.

3. *Drug abuse programs*—All nine states reporting for drug abuse programs have standards for drug abuse programs in development or use. In seven states these are being monitored. In one state these standards are those of the JCAH and two other states are considering using the JCAH standards for their own. Standards are required by the federal government.

4. *Alcohol treatment programs*—Of the eight states in which there were reports from the alcohol programs, six are being monitored. Here, too, there are strong federal expectations.

5. *Mental retardation, institutions*—(11 states) Three states have state standards in operation and two more have them in development. One state uses the JCAH standards and two others which have no present plans are considering using the JCAH standards as their own.

6. *Mental retardation, community programs*—(11 states) All states reporting on community mental retardation programs have standards: in operation (6); in development (3); or in early planning (2).

Looking at the entire table, all the states report that they are planning, developing or using either their own or JCAH standards. Although two states presently have no plans for standards for their institutions for the mentally retarded, they are considering the use of JCAH standards.

USES OF STANDARDS

The survey inquired about what uses were being made of the standards. In all program areas, the three major reported uses of standards (Table II) are correction of deficiencies, third party payment requirements and program development. Because the top three uses all received the same mean score, this rank ordering is derived by comparison with the ordering that the states gave the basic purposes of their standards (Table III).

The use of standards for program evaluation was accorded high priority by community mental health centers and drug abuse programs, while drug abuse, alcohol treatment and community retardation programs gave the use of standards for licensing a high ranking. One reason for the high use of standards for evaluation is that federal law requires evaluation. Although of little importance to other programs, mental hospitals ranked accreditation as one of their two most important uses of standards. The states explain that accreditation is necessary to receive third party and federal reimbursements, and that it can be used as one way to reduce liability in court cases.

BASIC PURPOSES

Mental health, mental retardation, drug abuse and alcohol abuse programs reported that the three most important purposes of their standards program are: to protect the health and safety of the patients; to systematically identify program deficiencies; and to assure that the programs obtain all the federal and other third party funds to which they are entitled. Mental health and mental retardation listed their next priority purposes as guiding program development and assuring the public of program quality. Drug abuse and alcohol abuse programs rank the purposes differently, giving staff development and program development as the next two priorities.

Some states reported that responding to the SREB survey was the first time professionals from all four of the mental health program areas had mutually discussed the purposes and associated philosophies of their respective programs.

TABLE I

PRESENT STAGE OF DEVELOPMENT OF STATE LEVEL STANDARDS BY PROGRAM AREAS

PROGRAM AREAS:	Mental Hospitals	Community Mental Health Programs	Drug Abuse Programs	Alcohol Treatment Programs	Institutions for the Mentally Retarded	Community Mental Retardation Programs
STAGE						
1. No plans	3[a]	3[c]	0	0	3[e]	0
2. Early planning	6	1	2	1	3	2
3. In development	0	2	2	2	2	3
4. In operation	4[b]	8	9[d]	8	3	6
5. Being monitored	3[f]	6	7[f]	6	2	5
6. No answer, not applicable, or unknown	1	0	1	3	3	3

Key:

a The numbers in each cell indicate the number of states giving that answer.

b Five additional states—3 states with no further plans for developing state standards; 1 state using JCAH standards but is considering additional state standards; and 1 state reported that it was using JCAH standards, but did not give any additional information.

c Three additional states are considering or have committed themselves to use the proposed JCAH's community mental health center standards.

d One state is using JCAH standards and two are considering JCAH standards as their own.

e One state is using and two other states are considering using JCAH standards and have no plans to develop their own.

f. The totals include those states that are using JCAH standards as state standards. Some states whose programs are actually being monitored did not report that the states were doing the monitoring because JCAH and not a state agency monitors their state programs. Refer to b, c, and d above.

TABLE II

USES OF STANDARDS AND/OR MONITORING INFORMATION FOR SIX PROGRAM AREAS

PROGRAM AREAS USES	Mental Hospitals *	Community Mental Health Programs	Drug Abuse Programs	Alcohol Treatment Programs *	Institutions for the Mentally Retarded *	Community Mental Retardation Programs	MEAN SCORES
1. Correction of deficiencies	6	8	9	8	6	8	7.5
2. Third party payment requirements	8	8	9	9	5	6	7.5
3. Program development	7	8	9	8	6	7	7.5
4. Program evaluation	4	9	8	5	4	6	6.0
5. Licensing	5	5	7	6	3	6	5.3
6. Funding**	5	4	6	5	4	6	5.0
7. Staff development	5	5	5	4	4	6	4.8
8. Accreditation	8	2	3	3	4	3	3.8
9. Staffing	4	2	3	2	5	4	3.3
10. States not having standards, not answering or questionable.	3	3	2	4	4	4	

*Frequency of states responding to uses. This includes responses for states using JCAH standards as state standards.

**Funding: The use of standards to determine the size of budget allocations or reallocations by the state to programs dependent on the level of standards being met.

Statements explaining the purposes and philosophies ranged from "in development" and "not applicable" to fuller explanations. One state said, "The primary reason for our department in developing standards is to insure the quality of care received by patients in mental health and mental retardation programs, to diagnose program weaknesses, and to provide assistance in correcting deficiencies. Standards will provide the frame of reference for their diagnostic and prescriptive activities." Another program wrote, "The reason or philosophy underlying the five choices is the assumption that people who are retarded are people first, and are entitled to the same rights and privileges as the normal population. The above selections rest on the premise that health and safety are key factors in whether or not benefit is derived from programming which meets certain professionally pre-determined levels of adequacy."

> "The standards are based upon the fundamental assumptions that alcoholism is an illness and persons who suffer from problems related to its use are entitled adequate and appropriate care. They set the minimal acceptable requirements which programs must meet and are used as a tool for evaluating program effectiveness and monitoring program activities to assure quality control."

> "This answer is not really accurate, as what this agency wants is not necessarily what the state legislature and other higher authority requires. The above answers represent the latter (reality!)."

MONITORING

As indicated in Table 1, the majority of states that have standards are monitoring them. A wide variety of monitoring procedures are used, although the greatest number of states and program areas responding (7) reported using some form of review by the staff of a central office. Four states rely on monitoring by an outside agency, which in three cases is JCAH. In the fourth case, the state contracts with a medical association to monitor treatment. Peer review and monitoring by regional office teams are each used by two states or program areas. A few states reported the use of self-monitoring with reports being sent to the state agency, and spot checks are then used for selected programs.

Almost all monitoring is performed annually, but one state visits some of its programs quarterly. The majority of respondents report that additional site visits are scheduled if a program is not in compliance. In some states monthly or quarterly progress reports are required from each program.*

Nine states report some degree of cooperation or coordination in the monitoring among program areas and/or agencies within their boundaries. In five of these states, cooperation is of a formal nature: one state coordinates all surveys for Titles XVIII and XIX, another for Title XX; one has set up a departmental coordination committee; and one has established a licensure consortium prototype. Coordination of standards and monitoring is being developed in two other states and exists informally in two more states. One state's standards program formally serves two program areas while informally serving the other two.

When asked if they would use standards even if they were not required to, over 75 percent of the survey respondents gave an affirmative answer and offered the uses to which standards would be put. The majority of the remainder gave some positive indication, but offered no explanation. The states said they would use standards to develop programs, improve communications between the state agency staff and service providers, provide a reference point against which to measure program progress, alleviate fears of partiality in measurement, bring a degree of uniformity to definitions and operating procedures, evaluate programs, assure quality and qualify for third party payments.

Currently 10 states are setting and monitoring standards under state enabling legislation, one state has an enabling act pending in the legislature, two are operating under administrative directives, and one's authority for standards is unknown.

BUDGET

Ten states reported their approximate annual budgets for standards. Figures are approximate for many states because the appropriation for standards is not listed separately in their budgets but may be included in a departmental office or as part of a standards and licensing program that covers more than generic mental health.

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*The number of states or program areas using these methods is not clear from the survey responses.

TABLE III

BASIC PURPOSES INVOLVED IN STATE MENTAL HEALTH AGENCIES' STANDARDS

Standards best serve to:	Mental Health f*	Mental Retardation f	Drug Abuse f	Alcohol Abuse f
1. Protect the health and safety of the patient.	14**	10	8	8
2. Act as a useful tool for systematically identifying program deficiencies and developing plans for correcting them.	9	9	6	6
3. Assure an agency's programs obtain all of the federal funds to which they are entitled.	9	6	6	5
4. Guide the development of programs.	8	7	4	4
5. Assure the public of a program's quality.	8	6	5	4
6. Guide training and development of staff.	6	4	6	5
7. Obtain minimal compliance from staff and programs.	6	4	3	3
8. Reduce an agency's vulnerability to liability.	4	4	3	3
9. Describe program and staff activities for planning and evaluation.	4	2	3	2
Total number of states responding ***	14	11	9	8

* Frequency of responses

** Number of states who feel that the statement reflects a basic value or philosophical assumption which forms the foundation of their agencies' processes.

*** Note: The number of states ranking each statement of purpose should be compared to the total number of states responding in each program area in order to produce an appropriate comparison between program areas.

Standards budgets ranged from $20,000 to $320,000, with four states annually spending more than $120,000 for standards and six spending less than $60,000. The mean expenditure is $103,000 and the median expenditure is $53,000.

STAFFING

A total of 103.5 people including 27 part-time staff and 5 volunteers, are involved in the standards operations in 13 states. Staff size ranges from one part-time person to 26 full-time staff members. Four states utilize 11 or more staff members, while nine states each have fewer than eight staff members assigned to standards. One state did not report its standards staffing. The mean for the 13 states is 7.9 persons and the median is six.

Of the 38 standards administrators reported by survey respondents, half held master's degrees (Table IV). Administrators with doctoral degrees and those who are doctors of medicine made up the next two largest groups. Only two administrators hold baccalaureate degrees.

The largest number of administrators are psychologists, followed by medical doctors and social workers (Table V). The reported professional backgrounds of all administrators represent 10 professions.

Administrator's annual salaries ranged from $12,000 to $40,000, with a median of $20,000 and a mean of $22,100 (Table VI).

STRUCTURE AND ORGANIZATION

In the winter of 1975-76, the 14 Southern states varied widely in their organizational structures. Seven of the states had grouped their mental health services into a larger agency (often named Human Resources) to provide more comprehensive and integrated human services delivery. Eleven of the states submitted organizational charts that located the office which has the major responsibility for mental health standards.

The functional ties of the standards office to other offices dealing with program evaluation, planning, the information system and fiscal responsibilities can be divided into relationships of high, medium and low or no intensity (Table VII). High intensity relationships were characterized by survey comments such as "an excellent relationship" and "works closely."

Medium intensity relationships were characterized by statements like "indirect but not formal contact." Statements such as "in development" and "what relationship?" characterized low or no intensity relationships.

Relationships of the state standards program to groups outside their organization primarily concentrate on federal agencies, JCAH and state fire and health officials. Seven states or program areas responding to the survey attempt to incorporate federal standards in the state standards, one has the regional office of the Department of Health, Education, and Welfare review draft comments, and one state that has no standards office directs its programs to comply with federal standards. Several respondents reported that they are in close touch with both the federal regional offices and JCAH. Six respondents incorporated JCAH standards into their own manual or urged their programs to work toward JCAH accreditation, while two more use JCAH standards as guidelines or references. Although several states accept the results of monitoring done by state or local fire and health officials and do not attempt to set their own standards for these areas, seven statewide sets of mental health standards incorporate the standards set by those officials.

Other than public hearings held on proposed standards, the relationship of state or program area standards personnel with the public is scanty. One state's legislation provides for a patient advocate; one program area incorporated the standards of a professional group in its manual; and one state receives input from regional planning councils.

TABLE IV

DEGREE LEVEL OF EDUCATION FOR STATE-LEVEL STANDARDS ADMINISTRATORS

Degree Level		Number	Percent
Master		18	50
Doctorate		10	26
Doctor of Medicine		7	18
Bachelor		2	4
Other (Specialty Degree)		1	2
	TOTAL	38	100

TABLE V

PROFESSIONAL BACKGROUND OF STATE-LEVEL STANDARDS ADMINISTRATORS

Profession	Number	Percent
Psychology	9	24
Medicine (Doctor)	7	18
Social Work	5	13
Education	3	8
Others*	14	37
TOTAL	38	100

*The "others" category included administration, communications, counseling, nursing, pharmacy, statistics and six unknowns.

TABLE VI

SALARY RANGES FOR STATE-LEVEL ADMINISTRATORS BY PROFESSION

Profession	Salary Range	Median	Mean
Psychology	$35,000-12,000	$17,500	$19,700
Medicine (Doctor)	40,000-35,000	37,500	37,500
Social Work	22,000-12,000	20,000	18,000
Education	25,000-18,000	21,500	21,500
Others*	30,000-12,000	19,300	19,300

*Others, as defined in Table V.

TABLE VII

LEVEL OF INVOLVEMENT OF STANDARDS PERSONNEL WITH PERSONNEL IN FOUR OTHER MANAGEMENT AREAS

Area of Management Areas	Level of Involvement		
	High	Medium	Low or None
Program evaluation	6	4	4
Planning	4	4	6
Fiscal	3	4	7
Information System	0	5	9

The survey results showed surprisingly less intense relationships than would be expected with the four management areas of program evaluation, planning, fiscal management and the management information systems. The majority of the standards personnel involvement was medium, low or none for all four management activities. No state reported high involvement with the management information system. Some of the reports of low or no involvement can be attributed to states which have no standards or are in the process of developing them.

Six states said that the standards administrator is a part of the management team at the agency level. Four states said he is not and three states gave no answer. One state reported that the standards administrator for mental retardation is on the management team, but the standards administrator for mental health is not.

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